HOME HEALTH CARE: THE ARIZONA PERSPECTIVE

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-NINTH CONGRESS

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HOME HEALTH CARE: THE ARIZONA PERSPECTIVE

TUESDAY, MAY 27, 1986

HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Sierra Vista, AZ.

The committee met, pursuant to notice, at 9:30 a.m., City Council chambers, Sierra Vista, AZ., Hon. Jim Kolbe (acting chairman of the committee) presiding.

Members present: Representatives Kolbe and McCain.

STATEMENT OF REPRESENTATIVE JIM KOLBE

Mr. KOLBE. Ladies and gentlemen, I think if we might, we will go ahead and get started here. I am sure some other people will be coming in as we proceed. I want to thank all of you for being here this morning for this hearing that Congressman John McCain and I are doing, a field hearing on the subject of home health care, the impact on the health care system for the aging.

I think all of you have been given an agenda, and you have some idea of the order in which we are going to go. We are going to do it as panels. Let me just tell you one correction to the way the agenda is printed here. We will ask for the opening statement from each of the members on the panel before we go to questions, then we will take questions from all the members of that panel. So, each member of the panel will give their statement, and then we will use the rest of the remaining time for questions.

I am very pleased that Congressman McCain, who serves with me on the Select Committee on Aging, perhaps I should say I serve with him, since he predates me on that committee, is here today to join with me in this, I think, very important hearing in Sierra Vista.

I would like to begin by making an opening statement. Each of us will have a statement, and then we will go directly to our first panel.

I think everybody enjoyed the Memorial Day weekend, and I am sure some of you were tempted to spend yet just one last extra day on vacation. I want to tell you I appreciate your being here today because I think that the attendance shows interest in this topic of discussion, home health care, and a genuine concern about the current status of this type of service, and what will happen to it in the future.

Home health care is hardly anything new. Before, we had acute health care in hospitals, home health care was really all that we ever had. Then, there was a time, of course, when we put all of our efforts and concentration on acute health care in the hospital setting.

It really was not until the enactment of Medicare in 1965 that most Americans began to think again, and we began to shift some of our focus to home health care. Today, we know that home health care plays a critical role in the lives of thousands of individuals and many more people simply have to do without it even though they have a need for the service.

With the implementation of the Medicare prospective payment, known as the DRG reimbursement system, which I will discuss in a moment, we are seeing even greater demand on the home health care services, at the same time we are trying to reduce health care costs and Medicare expenditures.

Let me take just a moment to introduce some of the important issues that I think are involved here in home health care, to perhaps set the agenda for the issues we are going to be discussing here today.

Home health benefits were first included in the Medicare benefit structure to provide assistance for those persons, especially the elderly, who need on-going care at levels lower than is provided in hospitals and who prefer to receive those services in the familiar surroundings of their home.

Home health care was perceived as a very much needed service, but lawmakers also anticipated that Medicare services would be made more cost-efficient with home health care by reducing the need for institutional services.

Currently, the law permits home health care services to cover under Medicare. The following services: part-time or intermittent nursing care, physical occupational or speech therapy, medical social services, limited part-time or intermittent services of a home health care aide, and medical services of interns and residents under an approved teaching program of a hospital, with which the agency is affiliated. All of these can be performed on an out-patient basis of the hospital, a skilled nursing facility or a rehabilitation center or under arrangements with a home health care agency and involving equipment that can be made readily available to the patient's residence and be done in the home setting.

I think we would agree this is a fairly wide range of services, but there are certain criteria for home health care eligibility which must be met to receive these benefits. Most significant, home health care regulations which deal with whether the recipient is home-bound, if services are required to meet the definition of part-time or intermittent, the determination of the need for skilled nursing care, the extent to which the services of the home health aide may be covered, and, finally, the basis for determining the degree to which home health care services are reasonable and medically necessary.

Given the continuing rising costs of health care and the Government's need to reduce costs, sometimes the criticism is made that these home health criteria are used arbitrarily to limit payment for or access to home health care.

For example, the regulations may put health care agencies in the position of rendering services to clients eligible for Medicare on physician's orders only to be told that the care is noncovered, and that the agencies will not be reimbursed. Then there are men and women who are eligible for Medicare that may be turned down because the condition may be considered not serious enough to merit home care, or it may be considered too serious to qualify for intermittent service.

I hope we will be able to discuss these assertions during today's hearing. Problems which arise from these kinds of subjective determinations are compounded by the simple fact that more and more people are becoming eligible for Medicare services.

In the last two decades, the aging population in the United States has grown twice as fast as the rest of our population. The median age for the U.S. population is projected to rise from 31 today to over the age of 36 by the year 2000, and the number of Americans, even with the rising number of Americans over age 60, the number in the Sun Belt has doubled as fast as the national increase in the aging population.

In Arizona alone, there are 670,000 men and women age 55 and older in the year 1985. Not surprisingly, the elderly are the heaviest users of health services. They account for 30 percent of all hospital discharges and one-third of the country's personal health care expenditures, even though they constitute only 11 percent of the population.

Simultaneously, health care costs are continuing to rise, and the Government's attempt to reduce Medicare expenditures are affecting health care. Today, rising health care costs have overtaken Federal spending for retirement income as the source for the greatest increase in Federal spending on the elderly.

Federal health spending was 2.7 GNP in 1983. Projections for the year 2030, 50 years away, indicates that it will be more than 5.7 percent for Social Security and disability payments compared with 6 percent for Medicare financing and other health care programs.

In an effort to contain health costs, the prospective payment reimbursement system or PPS as it is called was introduced. But the introduction of this system has raised the oft-repeated charge, one that we will undoubtedly hear again today, that Medicare patients are being discharged from hospitals before they are well enough to go home. This is a strain on home health care. Thus, the strain on home health care becomes even greater.

The concept of prospective payment schedules or DRG's is relatively simple. The Government makes reimbursements based on average costs for particular diagnoses. The Government sets a standard rate or an average cost for each category of treatment, known as the diagnostic-related group or a DRG.

If, though, a patient's condition does not improve after the assigned time period, and a designated amount for funding, the hospital either has to absorb the cost of caring for the patient beyond that time or discharge the patient. Discharged patients then have to rely on home health care, not just for intermittent services, but for care for relatively serious health problems.

Last year, Congressman McCain and I held a hearing in Tucson on the DRG system, and we certainly heard from people who were

telling us that there were early discharges taking place. We are going to hear from some of those same people today.

So, I think we are aware of the potential shortcomings of the system, and I think what we want to focus on today is how those shortcomings, if they exist, are affecting home health care.

We have a number of questions that we want to address today. Are the kinds of services Medicare covers adequate or should it cover other kinds of services? Are the regulations for determining eligibility for the home health care system realistic or should we be changing those?

How much impact is the DRG system having on home health care agencies? Are there any trends in health care positive or negative that we should begin to address at the Federal level through congressional action?

I look forward to hearing the testimony from our panelists and from those who will be participating from the audience.

Now, let me introduce my distinguished colleague, who is more than just a colleague, but a very good friend of mine, John McCain, who serves in the House of Representatives on the Interior Committee and the Foreign Affairs Committee as well as, as I mentioned earlier, serving with me on the Select Committee on Aging, which he has been on since he came to Congress in 1982.

John, we appreciate your coming to Sierra Vista to join in this hearing.

STATEMENT OF REPRESENTATIVE JOHN McCAIN

Mr. McCAIN. Thank you very much, Jim, and I would like to thank you for convening this hearing today, and I also would like to thank our panel of witnesses, some of whom come from some distance, in order to provide testimony today. I also would like to recognize Representative Bart Baker, who has, of course, had a long and deep involvement in this issue and we are pleased to have him here today.

As you mentioned, home health care is certainly not a new idea, and for most of our history, home health care has been the only type of care that was available.

Families did the best they could to care for the sick and aged, often relying on many other methods, such as hard work and good luck. In 1965, with the establishment of Medicare, this country went a long way in attempting to meet the health care needs of this Nation's elderly, and I am sure most of you know the preamble of the Medicare Act declares that access to quality health services is a right of all Americans.

Ever since then, Congress has attempted to promote and encourage the development of home health care. Language included in various reconciliation bills, and the Tax Equity and Fiscal Responsibility Act of 1982, encourages and supports the use of home care. In 1982, Congress established the Medicare hospice benefit, providing home care for individuals who were terminally ill, and we will hear from one witness today who will, I think, be able to describe the success of that very important program. Of course, one of the primary purposes of the DRG prospective payment system was to

move patients out of hospitals into less expensive community-based home care services.

But all is not particularly well, though. A study conducted by the Urban Institute in 1983 found that nearly 3 million elderly Americans in a total of 5.5 million Americans of all ages living outside institutions need some sort of home health assistance in order to avoid institutionalization. Unfortunately, Medicare and other Federal programs only provide limited home care to about 2 million people. This works out to roughly $2 billion or half of what this country pays for home health care.

On the other hand, more than $30 billion is spent on nursing home care. There appears, obviously, to be some kind of a bias toward institutionalization. However, I do not know why this bias continues to exist. Every study, poll or scholarly study indicates a broad national preference for home health care. Consumer satisfaction is high, costs are lower, and quality of life is improved in countless ways by utilizing home health care.

It is my belief that many of the people who live in nursing homes today could be cared for in a home or community-based setting at a lower cost and at a higher level of service. I hope that in today's hearing, we will feature an assessment of this situation and cover some of the ways we can facilitiate a greater use of the home health care benefit.

I would also like to follow up on the topic Congressman Kolbe and I discussed at our field hearing in Tucson last year. What impact have DRG's had on home health care? Much has been made of the so-called sooner and sicker discharge procedures which have taken place since the implementation of the prospective payment system.

Are those people being discharged from hospitals too sick to receive home care? Are they even told home health care exists as an option? If our witnesses could touch upon these points, I would be very interested in exploring them further.

Finally, I understand that recent actions by the Health Care Financing Administration, known better to all of us as HCFA, indicated tightening of procedures and discrimination against home care. There seems to be an onimous rise in the denial rate which has no relation to the level of care. Information on this problem will be greatly appreciated.

Are these changes based on law or regulation or are they merely changes in policy? Elderly Americans do not fear death. They fear the loss of control over their own lives. They fear growing old without the resources to pay for the health care they need to maintain proper quality of life.

I applaud President Reagan's actions to study the problem of catastrophic health care, and I believe home health care should be a major component of any such system, whether it be a Medicare part C or a voucher system.

With the advent of Gramm-Rudman-Hollings Deficit Reduction Act, there have been cutbacks in all areas of Government. We must investigate the role of the Federal Government along with the State of Arizona and local governments. Obviously, the American family will remain the primary care-giver of home health care.

However, we must determine how much and what kind of support these entities should offer, particularly in the common cases of families unable or unwilling to provide care.

Again, Jim, thank you for convening this hearing, and I look forward to our witnesses today, and I would like to point out to the panel and to the people here that I know of very few good ideas that come from Washington, DC. The reason why we have these health hearings is to receive the needed information in order to make and implement policies from the people who have to deal with the issues on a day-to-day basis.

These are the people we will hear from today, and we greatly appreciate your being here.

Thank you again, Jim.

Mr. KOLBE. Thank you, John.

I would also like to join in thanking our State representative, Bart Baker, for being here. Bart's contributions to health care as chairman of the committee have been substantial in this State, and I am sure we will be able to learn something from him today. I hope, perhaps, he will take something away from this hearing, too, because the issue really has to be addressed, both at the Federal, State and local levels. So, I think working together is extremely important.

Before we begin with our first panel, I would like to introduce the mayor of Sierra Vista, Jean Randle. Where did Jean go? Well, Jean is going to make a few introductions here. In any event, we are pleased Jean was here a few moments ago, and we are pleased to have the participation of the mayor in this hearing today.

Is Marion here? Where is Marion? Here she is. I would like to introduce Marion Bauhs in the audience. Marion is the NARFE Federal legislative aide-elect, I guess that is the new position that you are going to be holding, Marion.

Ms. BAUHS. For NARFE, not for you. I do not want to get you in trouble.

Mr. KOLBE. No, no, no; I understand that. Oh, you would not get me into trouble with that, Marion. For the National Association of Retired Federal Employees, also known as NARFE.

All right. Would our first panel, which consists of Harry Cooke and Belva "Billie" Baker, come up? Harry and Billie, come around there.

While you are getting there, let me introduce you two. Belva "Billie" Baker, is 66 years old, according to my sheet, and is just about to finish her doctorate degree. What is that going to be in, Billie?

Ms. BAKER. I just changed.

Mr. KOLBE. You just changed. So, it may take you a little bit longer then.

Ms. BAKER. It will take me a little longer.

Mr. KOLBE. Billie lives on the edge of Bowie, AZ, and, so, I think, quite clearly, we can refer to that as a rural part of Arizona. I think that what she will offer today is the need for services in rural parts of our country and it will be very useful to us.

She is currently on the Southeastern Arizona Senior Citizens Advisory Council. A little less than 2 years ago, she was on the plan-

ning and development board for the Southeastern Arizona Health Systems Agency, the HSA.

She is a retired registered nurse. Does not sound to me like she is very retired, and is also retired from the newspaper business, given 10 years of volunteer work in community services to the Bowie Health Clinic.

We do appreciate having you here today, Billie.

Harry Cooke is committee State legislative member of the American Association of Retired Persons [AARP], and the National Alliance of Senior Citizens. He is a senior intern to Congressman John McCain's constituency office in Tempe, and is a public advisor for the Central Arizona Mobile Home Owners Association.

Billie, we will begin with you, if you would like to make a statement. Let me just emphasize that we have your full statement, and we will be happy to put them in the record, if you would prefer to summarize them or however you want to do it. We want to be sure we leave time for questions for you.

PANEL ONE: CONSISTING OF BELVA "BILLIE" BAKER, R.N., SOUTHEASTERN ARIZONA SENIOR CITIZENS ADVISORY COUNCIL, BOWIE, AZ; AND HARRY C. COOKE, MEMBER, STATE LEGISLATIVE COMMITTEE, AMERICAN ASSOCIATION OF RETIRED PERSONS, TEMPE, AZ

STATEMENT OF BELVA "BILLIE" BAKER

Ms. BAKER. Our community is very small. We have 500 people, approximately, in our town. I do not count this as our community. Fifteen miles to the east of me is a community of 400 people. Each one of the little farms and ranches have practically a little town in their backyards. There are several families living there.

I realize that most of the home health care has to go to communities where they can cover the most people in the shortest amount of time, money wise. But we have got to consider that we have people in the outlying areas that cannot be reached without a little more effort and some travel time.

Now, this is the thing that has concerned me, and it is really quite shocking. We have had some very touchy situations that have arisen in the last couple of years, a lot of them because of the DRG's. In fact, I have had a couple hair-raising experiences myself.

A lot of us have moved out into the country with the idea that we can spend our retirement in peace and quiet. Well, the golden years are not that great sometimes. We need some medical care.

I am 90 miles from the nearest specialist. I am 120 miles from my internist. There are people that live 60 miles from me that would have to come 60 miles before they could go that 120 miles. We do have a health service, but no specialists or anything of the sort.

Therefore, we do need home health care. More and more elderly are living alone. We have a great deal of many, many older people now in our area. In fact, it is over 50 percent of the population where I live are over 55 years old.

It is a depressed area because so many of the farmers have had difficulties. Therefore, they do not have money to pay the visiting nurses. This was a little shocking to me to discover that those of us

that can pay, yes, but why can we not have some services for the people that cannot pay? And we have a lot of them.

We do not have Meals on Wheels. San Simon never has had Meals on Wheels for the elderly and the disabled. In our little town, we had one patient that was given food all at once for 2 weeks, frozen, to put in her oven, and the woman never should have been allowed to come home when she came home.

That is the only time we have ever had Meals on Wheels, simply because we are so far away. We can go into Wilcox to a senior citizens center and to see physicians. That is 27 miles from my home.

We see more and more elderly people that are living together. They still need services. They need someone to come by with an educated eye to see what is going on, to see whether the people are well.

I ran into a case this morning, it was brought to me at 5 o'clock this morning. I am no longer in community service, but how can you turn these people down? The man is unable to cook for himself. His house is in such shape that he is sleeping in his pick up. He is 80 years old. He needs someone to drop by and see and assess what needs done.

I am concerned because of the lack of education for the people that are being discharged from hospitals. They are not given the information of where to go for help, the various agencies are not told, the physicians probably do not have time to educate these people.

I am concerned because possibly the discharge nurses are not telling the patients what needs done. They are mixing medications. They are not getting the proper care. They are going home to situations where they cannot take care of themselves.

Many of these elderly people do not have family support. In my written statement, I had written about only three cases. They all came up within a matter of a week. So, the rural people really need help, and I do not know how to go about it.

The visiting nurses can give 20 minutes to 1 hour per patient. Is this enough? Possibly, it is, if they just need to take the vital signs. Medicare will not pay for just taking vital signs. The nurses cannot do it because they have to be paid. If Medicare will not pay it, the family has to come up with it.

We need home health aides to do the things for these people that they cannot do themselves. Maybe on a weekly setup or a biweekly setup, to take the vital signs, possibly even check for sugar, which is a big thing with the elderly people.

I know the paperwork is terrific for these people, so I would say that we need to increase our budget to give them a lot more aid. We need to cover more people. We need to get travel time for these people in the rural areas because they have to go 30 miles to see one patient. That patient is important, too.

I had never realized in the years that I was practicing as a nurse how terrible it must be to these people. We think it is a calculated risk when we move out there, and, then, all of a sudden, we are faced with it, that it is not so funny.

I have had another elderly person move into my home. My home is paid for. I cannot sell it because I am in a depressed area. I cannot go to a more metropolitan area. I do not feel I can live

alone anymore. This other person cannot live alone anymore. But at least there are two people there and one can rely on the other.

I find that this is becoming more and more. We have in our small community patients with Alzheimer's disease, muscular dystrophy. We have got stroke victims. We have got a paraplegic. Maybe I should say something about this.

We have households where the elderly are taking care of the elderly. One is a 70-year-old high blood pressure patient taking care of a 90-year-old mother that is in a wheelchair. It would be a big help if a nurse could come by once in awhile just to check that everything is well.

We have an 80-year-old woman taking care of a 60-year-old paraplegic son. We have got a woman, a senior citizen, taking care of a friend, who is a stroke victim that is completely paralyzed, in our area.

I do not know how to go about this, but I do know we need a bigger budget. We need more help. We need more medical aid.

I have had to resort on—to some of these things, a few times myself. For instance, 2 years ago, in an emergency, I was taken in the back of a pickup to Tucson for emergency surgery. After I hollered loud enough, we got an ambulance in our little town to take care of a radius of 90 miles each way.

But I had to meet the problem before I realized it was there. I was fortunate. I did not have to come home and take care of myself. I could go some place else. But I was alone when I broke my leg, and I was alone when I broke my arm, and 7 years ago, I broke my back, and I was alone.

It would be nice to have help in the home once in awhile. Somebody just to drop by.

Now, as I say, I am one of the fortunate people. I worry about the people that are lower income, cannot afford it, they need to make sure that they are educated in nutrition. They need someone coming by to take the vital signs. They need so many things, and they are so far out, so far away from all of the amenities.

Now, there is my problem.

[The prepared statement of Ms. Baker follows:]

PREPARED STATEMENT OF BELVA T. BAKER, R.N., SOUTHEASTERN ARIZONA SENIOR CITIZENS ADVISORY COUNCIL, BOWIE, AZ

I am Belva T. Baker, retired-living in Bowie. This is a community of approximately 500 people, mostly in the lower income bracket and more than 50% over 55 years old. I can only speak for this rural area- it's a farming and ranching area. Perhaps the lack of much home-health aid in our area is because of the sparse population and the amount of travel time to reach the outlying homes.

The restrictions of the DRG's have certainly increased the problems that we already had. Now, the elderly and disabled persons are too quickly moved from 'full-care' to 'no-care' without proper preparation or the facilities to assist. The home health care has not been expanded sufficiently to cover the need that has come about.

Some very shocking things are happening. Recently we have seen an increase in temporary but never-the-less acute needs. Most people do not know where to get aid and, even if they do, home-health seems to be unable to add more clients.

Also we see more elderly attempting to remain in their homes. Certainly most of them couldn't afford institutional care - and, I'm very sure, they don't want it. So, we need more senior programs to help them. Meals on wheels? We have had, in the past, frozen meals brought for a week or two to a patient discharged from a hospital to Bowie- but not beyond Bowie (such as San Simon or to one of the farms). Now we can't even get that. We have no transportation for out-patient surgery, for doctor visits, to specialists (nearest 90 miles) or to drugstores (nearest 25 miles) or for groceries (25 miles).

Recently I have seen more elderly people living together- because of no family support. A classic case- a single man with severe respiratory difficulties recently moved in with a couple because he 'didn't want to die alone'. The couple are also oxygen dependent. This would be fine- if they could have a home-health aide drop by occasionally to see that 'all is well'. But Medicare will not pay for just monitoring vital signs.

The paperwork must be horrendous and it would be a great help if more home health aides could be trained to do follow-ups, take vital signs. And, again, consideration must be given to travel time. So far most of the aid seems to be generated for the congested areas where more people can be visited with the least amount of time. I understand that the nurses are mostly limited to 20 minutes to 1 hour per patient. Guide lines are necessary but some lee-way must be considered. Not too long ago, a lady who lived a mile from me was released from a hospital, no neighbor knew that she had gotten a ride home. The hospital correctly notified the home health service.

So before the nurse went to the office the next morning, she stopped by for a suggested 20 minute call. She found the woman lying on the floor trying to get her breath, thinking that she was still getting oxygen from the bottle given her when she was discharged. The oxygen probably lasted long enough to get her home. Her air conditioner had not yet been serviced and couldn't be turned on, no food had been prepared and she had not eaten. She had not had the prescriptions for the very important heart and breathing medications filled. The nearest drug store was 26 miles away. Obviously, the nurse had to spend more than 20 minutes with her.

We have in our area patients with Alzheimer's disease, muscular dystrophy, stroke victims, as well as paraplegics and patients needing catheter changing, all of whom could be taken care of in their own homes among familiar things under appropriate supervision. Most of these people cannot afford rest homes. It would be more economic and these patients would be far happier, if we could give them dependable nurse supervision with follow-up by home-health aides. Weekly or bi-weekly visits at first, cutting down on visits as it becomes feasible. The funding for this should cover skilled observation, monitoring response to medication, checking for interactions of medication, and the education of the

care-giver. Also, some testing could be done by aides-such as bloodpressure, respiration, and sugar testing.

And, a very important thought to be considered, these home-health aides could give 'restive time' to the care-giver. These care-givers, often elderly, too, need a break once in awhile- a few hours to shop, to see a doctor, to just 'get away', or even just rest. A competent 'sitter' must be in charge.

We have parent and adult households. One is a 70 year old high blood pressure patient completely caring for a 90 year old mother, who is wheel-chair bound. And, there's a young 80 year old caring for a 60 year paraplegic. Close by is a 65 year old friend caring for a 75 year paralized male.

Education time is also needed for the support people by the visiting home health nurses. Physicians do little actual teaching and the discharge nurses at skilled nursing facilities have little time to assist planning for the patient. We hear of people mixing prescriptions- taking both old and new. This could cause terrible reactions and be life-threatening.

Then, we have the terminally ill who wish 'to die at home'. Recently, a man with terminal cancer was discharged from a hospital in Tucson, 120 miles from home, on a Sunday afternoon. He had a family to give him loving care. He brought home plenty of oxygen and lots of prescriptions. But he had a sub-clavial line because he could take nothing orally. The family had not been instructed. It was Sunday. The family tried to get the solution prescription filled in Willcox, all the drug stores were closd. Finally, they appealed to the small hospital in Willcox. Local physicians had to be contacted because the doctor in Tucson hadn't referred the patient to local physician or to a local home health office. It was not until Monday that the hospital contacted the home health office and they were able to make the man comfortable.

It all comes down to this:

We do not need cuts in funds.

We need an expansion of services- with some of them earmarked for rural needs.

We need education for the care-givers and restive time for those that need it.

We need better communications between health institutions and Home Health for discharged patients.

Then, we need weekly or biweekly visits for discharged patients.

We need more health aides and more time for them to check on elderly people who live alone.

We need more explanation.

We need Meals on Wheels for elderly and disabled rural residents.

We need transportation to and from doctors, hospitals, specialists, and drug stores.

We need house-keeping service for the disabled and some elderly.

I have only mentioned 3 cases in an attempt to be brief. There are many; each I have a story of near tragedy. I'm sure you know how much we need help in these rural areas.

Mr. KOLBE. Thank you very much, Belva, for that statement.
Mr. Cooke, we would like now to hear your statement.

STATEMENT OF HARRY C. COOKE

Mr. COOKE. Thank you.

I would like to address the broad scope of what home care may mean to our social and national values, and I am very supportive of this effort. I commend both Congressman McCain and Congressman Kolbe for the opportunity of speaking here today.

I represent what would be a total of 461,000 Arizona citizens. That would be 326,000 from AARP as members, 126,000 as NASC, and 9,000 as CAMOA.

Most of these people, of course, are mature citizens. Home care is not only a vital supportive elderly health program, it is a means of defending our natural sources, and what is rapidly becoming our biggest loss of self-supporting senior citizen population.

When ill health strikes the average elderly couple, and one member or both are forced to leave their homes or become a ward of the Government, at some level, and within 18 months from that date, their savings and property values are depleted, under nursing care costs.

We, as a nation, not only face this problem as a moral issue, but we must react defensively to what can become a major fault in our social structure. The numbers of the senior citizens is growing, and as you have well stated, Congressman Kolbe, a fast-lengthening widow population affecting the national health/welfare programs.

Constructive planning today could be the insurance against the senior dependency for tomorrow. We must recognize that only actions can prevent a massive "wards for the government" composed of senior citizens whose only fault is finding themselves living longer than the insurance firms' longevity charts state.

Keeping one's self-respect and independence is not a personal hope. It is absolutely mandatory to eliminate future major drains on our resources of health care facilities. This can be prevented and slowed by proper home care planning. It is not a question of will we do it. Just a decision of whether we do it now under good planning or on an emergency Band-Aid wasteful approach. Elderly who remain viable, pardon me, and productive put dollars into the economy, not take it out of it. This is our challenge of today. It is not a consideration of tomorrow. With the high percentage of widowed persons living on close to or below the poverty levels, any major increase in medical costs, doctor fees, medicine expense, pushes that individual into a state of dependency that would be irreversible.

No county in this State, no State in this Union, and no Federal agency can ignore that home care properly served can save in human lives and mental costs. Even the extended period of time offered in home care service can prevent the doubling of county role impactions, and the destruction of human beings.

Home care can also relieve the reliance of an elderly family member whose relatives could find financial jeopardy by an attempt to fully aid the family elderly member completely. Home care as a national aid plan should not be observed as a dole.

I would put to both Congressmen a challenge that we need a change in national attitude before we can have a home care that will fly. I would rather have an insurance to protect our Government agencies from untimely overloading of institutional facilities.

With the highest peaks of elderly persons coming into being in the years 2000 through 2020, there is good reason to plan for the doubling of our present elderly care needs. I recommend and assure you that the National Alliance for Senior Citizens and the AARP see the dire need for adequate planning of home care as a preventive measure to forestall the catastrophic negative loss of elderly who are now self-sufficient and undeniably on the threatened extinction list for remaining that self-supporting.

I thank the committee for inviting me to address this issue, and I commend its members for gathering widespread input to enable a helpful solution.

Thank you.

Mr. KOLBE. Mr. Cooke, Ms. Baker, we thank both of you for very good testimony. Do not leave, please. We are going to have a few questions here for you.

I will start with John. John?

Mr. MCCAIN. Thank you, and I would like to thank both witnesses.

Billie, I would like to thank you because I think that probably the most neglected portion of our population are the people that you are speaking for today, and that is the people who live in rural areas, and I think you have described very graphically the problems with access to the kinds of elementary care that is available to people who live in urban areas, and I appreciate very much what you had to say.

Harry, I appreciate you being here because I think that NARFE, AARP, and the National Alliance of Senior Citizens have long been in the forefront of trying to address these issues. We feel that your organizations are—the two of them that you represent, plus the retired Federal employees, are probably going to give us the guidelines for the solutions that we seek.

I will be very brief. Billie, you mentioned Alzheimer's disease. Do you think that home health care is the proper way to treat persons with Alzheimer's disease?

Ms. BAKER. In the beginning; yes.

Mr. MCCAIN. In the beginning?

Ms. BAKER. Most of the Alzheimer' disease people, if they are taken care of well and have the proper nutrition and the proper care, can be home for a long time, and they will—they really progress in some way, being amongst familiar things and familiar people. It makes a big difference in their well being.

Mr. MCCAIN. Thank you.

That leads to my next and last question for both of you, and that is one of a philosophical nature, and that is: Does the average family believe in home health care or is there a widespread perception that it is an outmoded idea, because we have modern hospital facilities in most areas of the country?

Ms. BAKER. The—I feel that most of us would prefer to stay at home. We are happier at home. I feel that it is not feasible to pay the big price for people to be in rest homes and sit around and wait

to die. Most of us would like to remain active, stay in our own homes, get out whenever possible.

The Medicare will not pay for a lot of things unless people are homebound. I do not believe in being homebound. People are young as long as they can use their brain actively.

Mr. McCain. Harry, would you like to comment on that question?

Mr. Cooke. Yes, I would.

Mr. McCain. By the way, speaking of being active, Billie, the former chairman of our committee, now chairman of the Rules Committee, who I believe is 86, Senator Claude Pepper of Florida, and I can assure you there is very little doubt as to his capabilities and his persuasive powers.

So, I certainly would agree with you.

Harry.

Mr. Cooke. As an individual who, 3 years ago, stopped playing baseball at 74, I think I have to admit that age is not a year. It is a condition. It is also a mental attitude.

Along with the idea of forming and constructing a good attitude between the generations, I think one of our problems is education, and we have in one of our organizations recently enacted a new idea called SCAT, S-C-A-T, which is senior citizens and teenagers.

I think the correspondence between those two groups is what is needed in our attitude and development toward a home care. Home care is definitely something that I think has come into more acceptance in the younger side of families because they see the ultimate destruction of all financial self-independence because of the increasing costs.

We are biting into the younger people as well as the older people on current notion care, home care, medical costs. I think this is the right time. I think home care today will fly, and I think that it has to be told in the manner in which it is an aggressive policy and there is no substitute for remaining in your present living acceptability and your surroundings.

I think it is a very, very adequate medical treatment of its own.

Mr. McCain. Thank you.

Mr. Kolbe. Ms. Baker, you referred to discharge nurses and the problems that people have, in your prepared remarks, about people coming home and having adequate services.

Do you see a major component of home health care, as better discharge planning, patient management?

Ms. Baker. Very definitely.

Mr. Kolbe. Is that not getting done now at the hospital level?

Ms. Baker. It is not. In my written statement, I gave you three cases where I mentioned specifics. On the planning for these people.

They need to be educated. They need to be told how to take their medications, how they can live, and live well, and they definitely, particularly in the rural areas—I am 27 miles from the nearest drugstore. I do not need to go home with a handful of prescriptions.

This is the thing. They need to be cautioned. They need to be told how to take care of themselves. The families need to be educated to it.

Mr. KOLBE. So, if we are going to have a DRG system that causes earlier discharge, whether or not it is appropriate or inappropriate, and I will not say whether it is necessarily premature, but it certainly does lead to quicker discharges from hospitals. There needs to be something at the other end when those people come out is what you are saying.

Ms. BAKER. Right.

Mr. KOLBE. Not only for home health care, but there has to be planning for that.

Ms. BAKER. Very definitely.

Mr. KOLBE. Maybe Mr. Cooke needs to address this question because I think it would probably fly more toward urban areas, but are there more services available in the urban areas that people just simply do not know about, that people are not aware of the services that are available to them?

Mr. COOKE. This is very true. It is sorry to say that in our electronic marvel world, communications is still our biggest problem, and education is No. 2, as far as knowing where to go with all the literature that AARP, for instance, and NASC distribute millions and millions, we still do not reach everybody.

There is a vast ignorance of the potential availability of services, but along within that, you cannot only offer the services; services are a code offering of health. You must admit to the fact that there is a humanitarian area that has to be cultivated also, and when you are speaking in terms of reverting again to home care, in talking about the hand-on-hand, which you have well illustrated here this morning, of the aid that—the beneficial contact a fellow person offers, this is not a cold issue of treatment or medicine and say go home and lay down.

That is not the answer. We have got to do better than that.

Mr. KOLBE. Do either of you think that the qualifications, by and large, of those people working in providing home health care services are good or is that a major problem, that we need more and better training for those home care individuals?

Mr. COOKE. I could really get into trouble in this body right here.

Mr. KOLBE. Try it anyhow.

Mr. COOKE. However, I hope none of them are armed.

As far as the quality, I would say it is not quality so much as the understanding of the basics of gerontology, and I am happy to see that we are finally trying to teach some people in the universities as to how it is to deal with older people.

This is the impossible mountain that you have built, between success on home care and the availability of people to carry it out. Very much education is the major line.

Mr. KOLBE. You are mentioning that as a problem for those in either nursing or home health care. It would seem to me that the problem would be even greater among the professionals, the physicians, then on really understanding senior citizens, elderly people and the elderly aging problem. They are so used to dealing with acute care in a medical setting, in an institutional setting, that do they really understand their problems when they are in independent living and being at home.

Mr. COOKE. That is right. I think it is very much of the order, if you want to be one, you have to be a part of that style, that lifestyle.

I think, though, that the understanding is increasing. I think education has taken some long strides, but with the increase of our enormous growth of elderly, the idea of understanding it from a mutual standpoint is still lacking. We only scratch the surface of gerontology, so to speak.

Mr. KOLBE. Ms. Baker, would you like to comment on that? On the question of adequacy of training and——

Ms. BAKER. I heartily agree with him. We need more training. Definitely need more training in taking care of the elderly. It is a completely different ballgame.

Mr. KOLBE. It occurs to me that our medical school curriculums, there are very few doctors practicing that ever really have any training in gerontology. We are just now beginning to offer that as part of the training, part of the regular curriculum.

Ms. BAKER. It has started.

Mr. KOLBE. Started, but——

Ms. BAKER. It has started.

Mr. KOLBE [continuing]. You have thousands upon thousands of physicians out there that have never really had any training.

Let me ask you this, for both of you. Is there more that the private sector ought to be doing? Do the churches and the—you mentioned the SCAT group, Mr. Cooke. This sounds like a terrific idea.

Is there more that the private sector could be doing to help provide for these home health care services?

Mr. COOKE. Yes; I think so. I also answer that with the cutting down of Federal funding, various agency budget cuts, what have you, I think you are going to have to be forced to go to the private sector.

What I think, when you go to the private sector, it might be well to talk to the, say, medical associations. It would not be bad to follow up your line of thinking, that the medical group have a little seminar and include gerontology as a part of their side issues.

Also, as far as the groups are concerned, we have on the average, 5 citizen areas, a 160,000 population, you will have 128 to 130 service groups involved in that population area.

Now, we do not utilize those service organizations, not like we should, and I am talking about groups like the Rotary, the Kiwanis, the Optimists, et cetera. That is a life blood of the community, and when you touch them, you touch everybody, professional and business people alike.

I would say that is where you should go. Education in that area would give you big results.

Mr. KOLBE. Thank you very much.

Did you want to comment on that, Ms. Baker?

Ms. BAKER. That is a new concept, and I think it is great. I feel that in the rural areas, we do not have the service groups that we can rely on. We find that possibly ten people in an entire area can work on the various things. They are the only ones that get out and work. We just do not have it.

Particularly in southern Arizona, we have a lot of itinerant workers, farmworkers. They are involved in their own problems, and their problems are tremendous.

Mr. KOLBE. Thank you very much.

I want to thank both of you for your testimony. It has been very helpful. We look forward to having you stay with us the rest of the morning and listen to what everyone else has to say.

Thank you.

Mr. COOKE. Thank you.

Mr. KOLBE. Could I ask panel No. 2, Robin Klaehn, Joan Lowell, Mary Beth Zanes, Mary Conlogue, and Stewart Grabel to come forward.

While you are walking down, let me begin making the introductions.

Robin Klaehn is the regional administrator for medical personnel pool, Home Health Agency of Arizona. The agency offers a full range of nursing and therapy services. The agency has developed two branch offices in underserved rural areas. She is a registered nurse, certified nurse administrator, and has a bachelor of science degree in home health care administration.

She serves on the membership committee of the National Association of Home Health Care, currently on the communications advisory committee. She authored with committee comment the 1984 statement on charity care by proprietary agencies for the proprietary section of the National Association for Home Care and served on a number of statewide committees, and I personally have been privileged to work with her.

I think, because of the number of witnesses on this panel, I will make the introduction of each as they begin their statement. So, Robin, we will ask you for your opening statement.

PANEL TWO: CONSISTING OF ROBIN A. KLAEHN, R.N., B.S., C.N.A., REGIONAL ADMINISTRATOR, MEDICAL PERSONNEL POOL IN ARIZONA; JOAN LOWELL, EXECUTIVE DIRECTOR, HOSPICE OF THE VALLEY, AND SECRETARY/TREASURER, HOSPICE ASSOCIATON OF AMERICA; MARY BETH ZANES, SOCIAL WORK CONSULTANT, DOUGLAS, AZ; MARY CONLOGUE, R.N., DIRECTOR, HOME HEALTH AGENCY, SOUTHEAST ARIZONA MEDICAL CENTER, DOUGLAS, AZ; AND STEWART GRABEL, DIRECTOR, COCHISE AGING SERVICES, BISBEE, AZ

STATEMENT OF ROBIN A. KLAEHN

Ms. KLAEHN. Thank you. Thank you, Mr. Kolbe, and Mr. McCain.

I appreciate the opportunity to address the committee once again on the increasing demand for quality home health services to Medicare patients in southern Arizona, and the implications of Government cost containment initiative on the availability for those critically important services. As I testified to you at your hearing in Tucson last September, we are seeing that more and more patients fall through the cracks in the Medicare system. Patients who represent the most vulnerable segment of our population. Under the relentless pressure to cut back expenditures, we are seeing those cracks widen, grow wider and deeper.

Last September, I advised you of an incessant barrage of new regulations emanating from the Health Care Financing Administration that are intended to ratchet down home health expenditures and severely restrict the access of Medicare patients to home health care. This is happening at the very time when the growth of the frail elderly population, their increased longevity and their earlier discharge from hospitals under the prospective payment system are creating greater demands than ever for home care, as a humane and cost-effective alternative to institutionalization. I said then that tightening the screws on Medicare providers has dire consequences for patients, and by shifting patients out of hospitals earlier, the prospective payment system shifts costs out of the hospitals that also increases the intensity of the input required to care for the significantly more complex home care case.

I testified that HCFA, apparently regarding the shifted cost as an unwarranted add-on to programming expenditures had initiated cost containment actions that seriously impede the ability of the home health industry to care for these patients, who are discharged quicker and sicker.

In the intervening months, we have seen additional HCFA measures to cut Medicare expenditures for home health: implementation of the massive paperwork of the plan and treatment forms of 485 and 488 resulting in seriously increased rates of denial for home health services in some parts of the country and slowdowns in claims payments that threaten to put some home health agencies out of business; proposed regulation that requires agencies to post bonds or establish escrow accounts in amounts that many agencies cannot possibly raise, particularly in the rural areas; proposed regulations to eliminate return and equity for home health agencies; and proposed regulations to eliminate the waiver of liability provisions for home health agencies.

Fortunately, through congressional action in the Consolidated Omnibus Budget Reconciliation Act of 1985, the waiver provision has been reinstated, but congressional action has also imposed the Gramm-Rudman across-the-board reductions that hit home health agencies, cost reimburse providers, with a 1-percent cut in payments. Under Gramm-Rudman, the Government expects to pay for care to its Medicare beneficiaries at less than cost. Clearly, the situation has worsened in these last months. As noted in a recent report of the Harvard Medicare project, policymakers have restricted coverage fearing unnecessary and perhaps uncontrollable increases in utilization of services. We think these concerns are exaggerated, said the Harvard study group.

Today, I want to address very particularly the implications that these exaggerated fears and of the HCFA cost containment policies for the availability of critical home health care services to residents of our rural areas in southern Arizona. These patients are most likely to be living in poverty, living in isolated mountainous areas, living with little or nothing in the way of family or social support network and, as you will hear in this hearing, they are dependent in many ways on a shrinking array of public sector services and resources that is unlikely to be replaced.

Yet, the enormous costs of reaching patients in our rural areas with the most basic home care services, services prescribed for

them by physicians, and which they are entitled to by law, simply cannot be recovered at the reimbursement level available under the Medicare Program presently.

Medical Personnel Pool maintains two branch offices in licensed home health agencies in southern Arizona; one in Green Valley, established 6 years ago, and another here in Sierra Vista, that we have operated for only 3 years. We are committed to these satellite operations and will keep them open as long as we can to help serve the home care needs of the patients in Cochise County, even though, in the rural areas, they are the classical losing proposition. We operate these branches actually at a financial loss, even though their accounting and administrative functions are borne entirely by the Tucson office. To put it another way: the actual payout costs to us in nursing and health care professional salaries, overhead, travel time, mileage, and supplies, are more than the Medicare cost limits for rural Arizona.

In fact, the shortfall is a direct result of the Medicare cost limit structure that, in my opinion, is not even remotely adequate in addressing the cost differential between the urban and the rural home visits in the State of Arizona. To illustrate, I would like to review for you some of the factors that drive the costs to us of providing a home care visit in rural southern Arizona. In Tucson, our service area is 100 square miles. The service area out of our Sierra Vista satellite office is 6,256 miles. Our rural Arizona patients are isolated not only by distance, but by mountainous terrain. Often, they are accessible only over unpaved roads that may become impassable during the monsoon season. Roads have been cut off by blizzards in the mountains of southern Arizona in the winter. Our nursing personnel are normally reimbursed per mile for their visit mileage. In Tucson, mileage costs account for about 7 percent of our cost limits per visit.

In rural areas, where nursing personnel may be required to drive for an hour or two hours to reach the patients, some compensation must also be allowed for their time en route. That can drive the mileage cost up to 46 percent or more of the per visit cost limit allowable under Medicare. On the average, our Tucson employees drive less than 500 miles per month. The average employee in the Sierra Vista office drives more than 2,000 miles per month, 500 percent of the Tucson average mileage and travel time. Not surprisingly, the number of visits possible per employee is about 28 percent lower in a rural area than in Tucson. Our costs per visit are also dramatically affected by low volume of visits out of the satellite operations. In Tucson, overhead costs are distributed over a much higher volume of visits than here in the rural area.

And, finally, the scarcity of nursing and other health care personnel with specialized skills in rural areas can add significantly to our cost of serving patients with special requirements.

Given these conditions, I am defeated by the logic of a cost limit structure that allocates the maximum payment of $52.64 for a skilled nursing visit in Tucson and a maximum payment of $54.21 for the same visit to a patient living alone on a mountain road 30 miles out of Bisbee, a difference of only $1.57.

Urban/rural differences for home health aide visits under the new HCFA cost limits effective July 1 this year, announced last Friday, are even more discouraging.

I would like to quote once again from the report of the Harvard Medicare project.

> In the long run, the most effective way to reduce inappropriate health care utilization is to provide an array of alternative social services, such as homemakers, meal services, respite and day care.

I believe this is no less true in the rural areas than the urban areas. No less true in Cochise County than in Tucson. Yet, under the new cost limits that came out last Friday, Medicare will pay $2.12 less for an aide to visit a rural patient than an aide to visit a patient in Tucson.

The critical issue, of course, is the plight of these patients in rural southern Arizona. As the cost limits are systematically reduced, who will provide for the care for these patients? Patients like the following, and I will give you just one of the three examples.

I will give you one that is particularly close to me. A 76-year-old veteran with severe cardiopulmonary obstructive disease living just outside Sierra Vista in a small mobile home. His sole support, a daughter, who is a military dependent torn between the needs of her immediate family's needs and her father's care. She chose her family. We found him in subsequent visits without food and without the physical stamina to perform even the most basic functions of independent life. Eventually, he was institutionalized.

In its introduction, the Harvard proposal states: "Younger Americans no longer have to choose between providing for their children and financing health care for their parents." Some still do.

As I testified to the committee last September, I believe the home care environment will be characterized by the following trends: Patients will continue to be discharged quicker and sicker; the demand for high-technology care at home will increase; the demand for more intensive patient education in the home will increase; family and community support systems for home care patients will be taxed beyond their capabilities of responding; more patients will find themselves victims of the revolving door syndrome as they are shuttled from one care setting to another; and more patients will fall through the cracks, discharged from hospitals and unable to qualify for home care.

In support of its proposal to extend the Medicare coverage to long-term care, the Harvard Medicare project argues:

> Medicare now pays for only a small part of the nursing home care and virtually none of the non-physician out-patient care of the chronically ill * * *.
>
> * * * As a society, we cannot in good conscience continue to deal with chronic illness in this manner. It robs the elderly of their dignity and of any real hope of economic and emotional security.

Similarly, I would submit to you that we cannot in good conscience continue to deal with the increasing home health care needs of the elderly whether urban or rural by systematically dismantling the existing home health benefits and driving providers from the market in the service of shortsighted budget cutting targets.

Such a policy will, in effect, expand the existing no care zone, robbing Medicare beneficiaries of the care to which they are entitled and leading, in the longer term, to even higher costs to the health care system and to the society.

Thank you.

[Material submitted by Ms. Klaehn follows:]

MEDICARE COST-LIMITS COMPARISON

	New 1986 limits		Old 1985 limits	
	Tucson	Rural	Tucson	Rural
Skilled nursing	$52.64	$54.61	$55.08	$52.78
Physical therapy	50.50	56.18	52.86	54.20
Speech therapy	57.19	64.78	60.00	62.24
Occupational therapy	53.10	60.89	56.10	59.57
Medical social worker	78.92	76.85	82.10	73.88
Home health aide	34.00	31.88	35.56	30.85

Mr. KOLBE. Thank you very much for your comments, Robin. Very good testimony. You belong here.

Joan Lowell. Joan is the executive director of the Hospice of the Valley. She is on the board of the Arizona Association of Home Care, currently is secretary-treasurer of the Hopsice Association of America, and a member of the National Association for Home Care, and the Arizona Hospice Organization.

She has been meeting for several years, I know, with Members of Congress in Washington to discuss home health care, and I certainly have heard from her on these issues.

Joan, we are pleased to have you here today.

Ms. LOWELL. Thank you.

Mr. KOLBE. Before you get started, let me emphasize once again to all of you that if you have more complete testimony, it will be submitted entirely in the record. So, if you would summarize, it would help us leave time for questioning.

Thank you.

STATEMENT OF JOAN LOWELL

Ms. LOWELL. I thank you for this opportunity, and I represent not only my agency, but my colleagues around the State.

You touched upon a lot of issues that we are dealing with, and I would like to address three of them. One is the way the families feel about home care, and that was a question you asked before. The second is about the problems we are working with, and the third is the way we ask Congress to help us.

You talked about what were families' attitudes toward home care, and I would like to read a letter from one family who we recently served.

I would like to express our family's appreciation of the role the Hospice played in caring for my mother, Pearl Carroll, until her death on March 6th, 1986.

With your help, we were able to give my mother the care and love that she needed during her illness, allowing her to stay in her home and dying with serenity and with dignity. Being with us, she was able to stay in touch with life until the very end, surrounded by the business of our lives, phones, visitors, work, dog. They gave her so much pleasure.

Our involvement with the hospice program allowed our family to make of my mother's illness and her death an experience that was positive and beautiful for all of us. While my mother was with us in our home, we saw her discard the masks that had served so well over the years in her struggles alone, and we became closer to her than we ever had been. In turn, we took the responsibility of caring for her as an opportunity to show our love in a concrete way and the only thing we could do in her defense against the disease that took her life.

Very importantly, it allowed our 16 year old daughter, Laura, to be with her grandmother until the day she died, discovering day-by-day the depths of the bond that had developed between them. Laura was able to experience her grandmother's death at close range and to understand that it was welcome as a liberation and release from pain.

I think that demonstrates what hospice and what home care means to people, and people do want the opportunities to work and to help the family members who are sick. We have found that.

Some of the problems that we are encountering are, as you mentioned, the denials. Our agency had no denials from 1980 until 1986. Then, we had 9 in one month, and 53 the following month. We are not alone. There was an agency in New Jersey who had a 27-percent increase in denials one year and 65 percent the following year.

The denials are coming from different interpretations and the way the rules and regulations are being written and being interpreted by the fiscal intermediaries, and, so, there is very little way of predicting when we are going to receive a denial. This is an area that we are trying to work with.

In Arizona, we are meeting with the fiscal intermediary on a regular basis, both as a group and as individuals, so we can better understand what they are asking us for and so they can better understand what we are dealing with. For example, they wanted, in one situation, a 15-year-old daughter to do the personal care, the bathing, and the very personal care for her grandmother. Well, we thought that was not appropriate and that a home aide was needed in that case, and they did agree with us on that one.

Robin mentioned the paperwork increase, and the agencies who can afford the time have analyzed what that costs, and it has led to an increase of 20 percent on home—on each visit because of the additional paperwork that was needed to be done.

At one time, we were able to provide without any difficulty care to patients with catheters, and nurses know that the catheters need to be washed and to be taken care of well, and now we are being told that a neighbor or a friend or someone else will be doing the catheter care, which is not reasonable in our estimation, and, again, we are experiencing a raise in payments.

So, we are trying to take action to deal with this by meeting with the intermediaries, by sharing with them what the effects are of these changes in the interpretation, and what I would ask of you is to consider three areas.

One is the 1-percent cut that Robin mentioned. That is against our costs. It is not against a cost cap, and that affects dramatically the way our funding comes in.

The second area is the cost limit, and I have sent each of you, I believe, a note about that, that you are not allowing us to aggregate costs now, which especially alleviates the problems in the rural area because if you can aggregate your costs for a visit in the

rural area with the cost in the urban areas, you can better deal with the expenses.

And, the third is ask Congress to reevaluate with the changes that are happening in the DRG's, reevaluate the regulations and the requirements for home care.

Thank you very much.

[The prepared statement of Ms. Lowell follows:]

PREPARED STATEMENT OF JOAN LOWELL, EXECUTIVE DIRECTOR, HOSPICE OF THE VALLEY; AND SECRETARY/TREASURER, HOSPICE ASSOCIATION OF AMERICA

Mr. McCain and Mr. Kolbe, thank you for the opportunity to share with you the concerns of home health agencies in Arizona and in the U.S.

My name is Joan Lowell. I'm the Executive Director of Hospice of the Valley. On the Board of the Arizona Association for Home Care and Secretary/Treasurer of Hospice Association of America. And a member of National Assn. of Home Care.

There are three areas I think are most important - what our families tell us are the values of home care, the difficulties we're experiencing as providers, and ways that we believe Congress can help ensure that home care will survive as a valued and appropriate part of the health care system in Arizona and the U.S.

To begin, I'd like to read to you part of one of the more eloquent letters we received from one of our families.

Dear Ms. Lowell:

I would like to express our family's appreciation of the role the Hospice played in caring for my mother, Pearl Carroll, until her death on March 6, 1986.

With your help, we were able to give my mother the care and love that she needed during her illness, allowing her to stay in our home and die in serenity and with dignity. Being with us, she was able to stay in touch with life until the very end, surrounded by the busy-ness of our lives--phones, visitors, work, dogs--that gave her so much pleasure.

Our involvement with the Hospice program allowed our family to make of my mother's illness and her death an experience that was positive and beautiful for all of us. While my mother was with us in our home, we saw her discard the masks that had served so well over the years in her struggles alone, and we became closer to her than we ever had been. In turn we took the responsibility of caring for her as an opportunity to show our love in a concrete way, and as the only thing we could do in her defense against the disease that took her life.

Very importantly, it allowed our 16-year-old daughter, Laura, to be with her grandmother until she died, discovering day by day the depth of the bond that had developed between them. Laura was able to experience her grandmother's death at close range and to understand that it was welcomed as liberation and release from pain.

On a more personal level, I experienced the benefits of home care (provided by another of Arizona's agencies) when my 79 year old mother-in-law had bypass surgery last year. She came through the surgery well but suffered a burst by-pass the next day, had to be reopened right in her room and suffered a severe drop in blood pressure. We saw a dramatic change in her behavior. From the warm, lively independent woman she'd always been, she became agitated, disoriented, hostile, continually ripped off her clothes, pulled out her tubes and had to be restrained at all times even though she was never left alone. After several weeks, her physical condition improved but her behavior remained completely negative and atypical for her. The disorientation improved only slightly.

The physicians and social worker at the hospital advised us to place her in a long-term care facility. Her cardiologist and our family believed that her only chance for recovery was to return to her own apartment where she'd lived alone for the past three years. After arranging for home health services and for daytime help (we all work), she moved back home. The home health nurses came daily to treat and change the dressings on her open wounds. The physical therapist came once to teach me how to help her exercise and climb stairs.

The change was extraordinary. After three weeks, she insisted that we dismiss the daytime help. She had by now regained her grasp on reality and her ability to dress herself. With the daily and then less frequent visits over the next two months by the home care nurse, her wounds healed and her medications became stabilized. A neighbor and the family came by daily to be sure of her meals and her general safety.

It's now 11 months later. She is once again completely independent. She lives alone, does her own shopping, cleaning and cooking, and has recently begun to handle her checkbook and pay her own bills. She has recently had the joy of a new great grandchild and her granddaughter's graduation from law school. She has a new lease on life.

Home health care made it all possible.

Unfortunately, HCFA and the administration are setting up roadblocks and constraints that prevent the kind of care my mother-in-law and Mrs. Boich's mother received. For many agencies denials are increasing by unprecedented numbers and for invalid reasons.

From 1980, when we started, to March 1986, our agency had no denials. In March 1986, we were denied 9 visits. In April, we were denied 53 visits. We haven't done anything differently. My colleagues are reporting similar experiences. But this is not limited to Arizona. An agency administrator in New Jersey reported that from 1983-84, his denials increased by 27%. In 1984-85, they'd increased an additional 65%. In additon, he reported that the HCFA is requiring fiscal intermediatries (FI's) to find at least $5.00 in disallowed claims for each dollar of the auditors salary. Depending on the timeliness of the review, denials may be made on visits delivered months earlier.

Two of the areas most targeted now are care of patients with catheters and families where the caregiver is unable to provide personal care. Nurses know that if catheters are not carefully maintained, patients develop serious infections that result in hospitalization. Yet, the FI's are denying visits for catheter patient's care. They are asking that unskilled family members or friends or neighbors provide this care. An agency had to convince the FI that the severely alcoholic daughter of a patient was unable to provide the personal and wound care her mother needs to recover from her surgery.

Appeals of these denials, even when won, add to the cost of care and to the financial burden of the agency. In addition to denial, we are experiencing reimbursement delays of 2 months or more.

We in Arizona are making every effort to resolve these problems with our FI's. We are meeting, as a group and as individuals, with representatives of the FI's to understand the changes that they are experiencing and to help them see the human side of our service. We are maintaining ongoing dialogue so that we can be current on the regulations and that they can hear our concerns. Our hope is that we can help each other.

You have heard before of the discrepancies of the interpretations of intermittent care, the frequent changes in interpretations of the regulations and the burden of new paperwork. Several agencies have studied the effects of the paperwork on costs and productivity and found that it has increased costs per visit by 20%. Happily, because of HCFA's understanding of the impact of the forms, a small change is planned for the paperwork, but even these changes will cause hardships at first.

You and your colleagues can help home care survive to provide the care that 98% of people interviewed want. Three specific areas need your support.

As I mentioned to you when we visited in March, the Gramm Rudman 1% cut affects home care differently from the way it affects other areas. Home care is a cost based program of reimbursement, not a prepayment one. Though there is a capitation, we are reimbursed based on costs. Therefore, if we are efficient, the cost to the government goes down. But, if you apply the 1% reduction to our costs, we are being reimbursed below our costs. This leaves us in a deficit operation. We ask that you contact the Director of HCFA to ask that he not impose the 1% reduction on the cost.

Another area where we need your help is the movement by HCFA to set cost limits. In the past, agencies could aggregate costs of different services to calculate cost limits. This allowed agencies to provide more expensive services because they could average the costs with less expensive services. Now, HCFA is requiring cost limits for each separate area and has changed the reimbursement formula. They are using data from the 1983 cost reports in setting the cost limits because they have not completed review of the 1984 cost reports. With this change, agencies, particularly in rural areas, are being forced to cut back on more expensive, but needed services. As a colleague put it, HCFA is pushing us into a mode of minimal to adequate care rather than good care - this, at a time when patients are coming home with more acute needs than ever before.

A third area in which you can help is to look again at reforming Medicare home health coverage criteria, particularly regarding the intermittent care requirement and needs assessments. (Senator Heinz raised this issue last year.) Better criteria addressing real needs will eliminate many of the difficulties faced by beneficiaries, their families and those of us committed to provide good services to these citizens.

Thank you very much for the opportunity and for your interest.

Mr. KOLBE. Thank you very much.

Our next panelist is Mary Beth Zanes. Mary Beth has a master's degree in social work from Florida State University. She is currently in private practice. The majority of her consulting work is in health care facilities.

She has been employed in the area of social work for the last, well, 20 years or so. She has also been a small business owner for the past 18 years, and has lived in Douglas for 15 years. We are very pleased, Mary Beth, to have you here with us today.

STATEMENT OF MARY BETH ZANES

Ms. ZANES. Thank you.

I appreciate this opportunity to speak with you this morning.

Most of what I have submitted in my testimony has already been said today. So, rather than read my testimony, I will try to make a few comments about providing home health service in rural areas.

I think it is fair to say that as the older person in our society grows less well, he often becomes isolated from friends, family and community. These problems are multiplied 100 percent when you get out in the areas, like Bowie, Wilcot, onto the ranches.

It is very difficult for people to receive services. This is complicated by the fact that a majority of the routine social services that would be available in Tucson or Phoenix or any other metropolitan area are not available in small towns. Once you get outside the small towns, they are almost nonexistent.

The result is oftentimes if you have a patient who is receiving care from a home health agency, the staff member from home health is their link to community. That may be the only person they see for 2 or 3 days at a time.

It is also terribly true, as has been mentioned here before, that the transportation problem in Cochise County is very difficult to overcome. It is not unusual for a worker in one of the home health agencies I consult with in this county to drive 150 or 200 miles a day. Maybe even more, if they go to the far ends of the county, such as Bowie.

There is a home health agency that provides service into the Bowie area, but it is very difficult for the staff to see a reasonable number of patients if they are driving 200 miles a day on top of it.

In my opinion, many of the rural home health agencies, like many of the hospitals in rural areas, will not survive if Medicare requirements and cost limits continue to become more restrictive. As the rural hospitals and the rural home health agencies disappear, the quality of health care for the rural American will be greatly diminished, if not nonexistent.

With regards to some of the comments that were made by the first panel, and by other people here today, I would like to say that more tax dollars may not be the only answer to continuing or expanding home health services.

Some revision in the Medicare requirements would certainly help to bring down the cost of delivering these services. I heard one of the people before me mention educational levels of staff members. I am not sure that we would not be better off if we looked at

a different type of training and education for people working in home health.

I am sure that within my own field of social work, I do not think it is necessary to have a master's degree to provide social services to people on a home health program. It costs a whole lot more to hire someone with a master's degree than it does to hire a person with 2 years of college and some special training.

I think this would be a great step to cutting costs. I also think that something needs to be done about the requirements for documentation and explanation of services for reimbursement and about the delays of reimbursement.

Being a small business owner, I know that it is impossible to keep your doors open if you do not receive payment within a reasonable number of weeks.

The third area I would mention would be what appears to be a more strict Medicare criteria for serving patients. I think that you can spread your cost factor if you can increase the number of people you serve, and I think in Arizona, especially, more than many of the other States in the country, that there is a desperate need for some type of governmental program which would provide custodial care to people in their own homes. This would allow the individual who does not need skilled care and does not currently qualify for home health services under Medicare reimbursement to be included in a home health program.

Thank you.

[The prepared statement of Ms. Zanes follows:]

PREPARED STATEMENT OF MARY BETH ZANES, SOCIAL WORK CONSULTANT, DOUGLAS, AZ

My name is Mary Beth Zanes. For the last 15 years I have resided at 2411 9th Street, Douglas, Arizona, and have been self employed as a social work consultant. The majority of my consulting work has been with health care facilities, more specifically with programs providing health services to the geriatric population.

For the last two to three years I have worked with three Home Health Agencies in Cochise County - two hospital affiliated agencies and one free standing agency.

In 1900 only 4% of the nation's population was 65 years of age or older. By 1985, that percentage had nearly tripled to 11%. By the year 2020, if current trends continue, those 65 or older will make up 20% of the population. The fastest growing segment of the population is a group 75 and older.[1]

Assuming that advanced age usually leads to increased use of health care services, these statistics indicate that within this decade the majority of patients in most hospitals will be over 65 years of age and receiving benefits from Medicare. This is already the case in many hospitals.

As the older person in our society grows less well, he often becomes isolated from friends, family, and community. Since the primary requirement to receive Home Health services is to be homebound, this problem of isolation is often accentuated for our patients.

In rural Arizona, Home Health services allow the older individual to receive skilled health services in the home, support families in caring for loved ones, provide education and rehabilatative services to enable people to return to independent life styles, and help the terminally ill who choose to stay at home, to die with dignity in the surroundings in which they lived.

Growing old in rural America is often complicated by lack of support services and by nonexistant transportation. The services of private and governmental agencies available to the city dweller are lacking in small towns and the ranching lands of Southern Arizona. For many of our clients, the Home Health staff member is their link to the community and the support system which keeps them at home and out of a nursing home. Home Health service is often the catalyst which makes a full recovery possible.

The benefits of Home Health services are numerous. Unfortunately, the restrictions on who may receive Home Health service under Medicare are also numerous. As the Medicare criteria for admission to Home Health programs grows more restrictive, increasing numbers of older people needing assistance are denied care. Many sick and aging individuals require total care, but do not require any skilled nursing service, physical therapy, speech therapy, or occupational rehabilitation. Without the ability to demonstrate clear need for one of the four above mentioned services, older individuals must be denied all the other support services which are available through Home Health agencies.

In the state of Arizona, there is a desperate need for some type of governmental program which would provide a "Custodial Care" service to our older population. This would allow individuals who do not need skilled care to remain in their home, and receive the daily routine personal care which is required to keep them out of a nursing care facility.

In my opinion, small rural Home Health agencies like many small rural hospitals will not survive if Medicare requirements and cost limits continue to become more restrictive. As the rural hospital and the rural Home Health agency disappear, the quality of health care for rural Americans will diminish greatly.

Currently, in one of my Home Health agencies, the cost of an average home visit for skilled nursing care runs $65.53. Currently, the Medicare cost cap to that agency for a skilled nurse home visit is $62.36. Regardless of the dedication or skill of the Home Health professional in the rural areas, cost factors such as these will demand the termination of Home Health services to rural areas.

As the aging population in our country expands, there is a need to expand and increase the services covered under Medicare and provided by Home Health agencies.

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[1] Vogel RJ, Palmer HC (eds): Long Term Care: Perspectives from Research and Demonstrations. Rockville, Md: Aspen Systems Corp, 1985.

Mr. KOLBE. Thank you very much, Mary Beth.

Mary Conlogue is a graduate of the University of Arizona, has worked in Cochise County ever since. She has been the associate director of the Nurses of Benson Community Hospital for 4 years, director of nursing at Copper Queen Hospital in Bisbee, but currently serves as the director of the home health agency, Southeastern Arizona Medical Center in Douglas, and we are very happy to have you with us this morning.

STATEMENT OF MARY CONLOGUE

Ms. CONLOGUE. Thank you.

I appreciate the opportunity this morning to speak before you, and I was happy to hear from your opening remarks that you both seem to be very well informed about what is going on in home health and that you share some of the concerns that we have as providers.

As you mentioned, home health care is not a new proposition, but over the last 30 years, the practice of medicine has changed. With the development of sophisticated diagnostic tools and treatments, people who became ill were almost invariably admitted to the hospital and stayed there until they were well. When I first began to practice nursing 8 years ago even, the average hospital stay was two or even three times longer than it is now. With the new reimbursement regulations the Medicare system has placed upon hospitals through the use of DRG's, the emphasis now is to treat the patient who is hospitalized as efficiently as possible so that the doctor can reduce that patient's length of stay. Diagnosis is generally made prior to admission and once hospitalized, the patient's treatment is intensive in nature.

I do not feel that these changes have all been bad. More testing and simple procedures are done on an outpatient basis, and providing medical care to the patient in his own home has, again, become acceptable and, in some cases, even preferable to hospitalization.

It is amazing to note the types of care that can be safely provided in a home. Intravenous rehydration therapy, total parenteral nutrition, wound care, intravenous antibiotics, the list goes on and on, and there is no reason that family members cannot be trained to help an ill loved one with a bath, provide a nutritious and therapeutic diet, give oral or even injectable medications prescribed by the doctor, and change a dressing on a wound. From the patient's point of view, the best part is that he will generally recover faster at home, close to loving family members and among familiar and comfortable surroundings. From the system's point of view, to provide care in the home is much less expensive than in the hospital. For simple pneumonia, for instance, the Medicare DRG reimbursement amount to our hospital is $2,363.82. In our agency, we can provide the patient with 3 weeks of home health care in the form of skilled nursing and home health aide visits for $1,305. This is a savings of $1,058.82. And, while the patient is recovering at home, the home health care team will be coordinating community resources and teaching the patient and his family how to prevent the disease from recurring.

I have highlighted some of the good things about home health, and almost all of the negative aspects revolve around reimbursement issues. Upon admission, all of our Medicare patients are reviewed by a registered nurse of Blue Cross-Blue Shield, our fiscal intermediary for Medicare. Copies of the doctor's orders on every patient are mailed to Phoenix on admission and again in 60 days if the patient is still in service. A determination is made in each case whether or not the services were medically necessary and at times, payment is denied for our services. In addition, this individual review takes a great deal of time and delays our reimbursement for weeks or even months, depending on the workload at Blue Cross. This strict review and regulation of our services and the delays in reimbursement for Medicare are devastating to any agency, but especially to a small rural agency and to our patients. Many times we are unable to provide needed care to patients because they do not meet the strict Medicare criteria for our care to be reimbursed. In this area, we do not have the resources to provide custodial or maintenance care for our senior population. While Cochise Aging provides many of these types of services, this organization does not have the funds or the staff to provide for all of the unmet medical needs of our seniors.

These reimbursement and regulatory problems have led to some innovative programs in our area. Our hospital is offering a program to assist Medicare patients with medical expenses that are not covered by the Medicare Programs. Some of the benefits include a discount on prescription medications, discount on their Medicare inpatient deductible, helping in completing their insurance forms, free hearing and hearing aid testing, quarterly affirmative aging seminars, which are all free of charge to the public. The program is called [TLC] Total Live Care for Seniors, and is run through our home health agency. There is an annual membership fee of $10 per year, which is affordable to those seniors on fixed incomes.

Since we began the program in late August 1985, we have enrolled nearly 800 senior citizens in the Douglas area alone. The community's response to TLC has been tremendous and emphasizes the concerns our seniors have about their health needs.

Another innovative approach to the reimbursement problems we have experienced involves the sharing of services. Our home health agency at Southeastern Arizona Medical Center has contracted with Copper Queen Hospital in Bisbee to provide home health care for patients in Bisbee. Together, the two offices cover our corner in southeastern Arizona and share resources and administrative expenses as well as staff, if necessary. While neither agency could survive independently, the shared services and increased patient loads from two hospitals has allowed both agencies to remain viable and provide the home health services our patients need.

In conclusion, I believe that home health care is the direction that medicine is now and will be taking in the future. With the high cost of providing care in the hospital and with the reimbursement environment imposed by DRG's, it will become increasingly apparent that home health is an effective and relatively inexpensive way to provide care, especially for our Medicare population. In addition to being cost-effective, we hasten the patient's recovery in

a most therapeutic environment, his own home, while providing him with the knowledge and skill he needs to prevent or minimize further episodes of ill health. While each home health agency has the responsibility to be innovative in controlling expenses and operating efficiently, we need help in solving our reimbursement problems and most of all, assurance that Federal Medicare regulations will not make it any more difficult for us to provide home health services for Medicare patients.

Thank you.

[Statement of Ms. Conlogue follows:]

PREPARED STATEMENT OF MARY CONLOGUE

My name is Mary Conlogue. I have been a registered nurse for eight years and since my graduation from the University of Arizona, I have practiced nursing in Cochise County. I was formerly the Director of Nursing Service at Copper Queen Community Hospital in Bisbee, and for the last year, I have been employed at Southeast Arizona Medical Center in Douglas as Director of our Home Health Agency.

I am here today to tell you about Home Health and its value to the senior population in our area. Home Health Nursing is not a new concept. Years ago, the Visiting Nurses' Association carried black bags and supplies to patients in need of care in their own homes. The old country doctor spent as much time out of his office making house calls as he did in his office seeing patients.

Over the last 30 years, however, medicine changed. With the development of sophisticated diagnostic tools and treatments, people who became ill were almost invariably admitted to the hospital and stayed there until they were well. When I first began to practice nursing 8 years ago, the average hospital stay was two or even three times longer than it is now! With the new reimbursement regulations the Medicare system has placed upon hospitals through the use of DRGs, the emphasis now is to treat the patient who is hospitalized as efficiently as possible so that the doctor can reduce that patient's length of stay. Diagnosis is generally made prior to admission and once hospitalized, the patient's treatment is intensive in nature.

I don't feel these changes have all been bad. More testing and simple procedures are done on an outpatient basis and, providing medical care to the patient in his own home has again become acceptable and, in some cases, preferable to hospitalization.

It is amazing to note the types of care that can be safely provided at home—intravenous rehydration therapy, nasogastric tube feedings, total parenteral nutrition, wound care, intravenous antibiotics—the list goes on and on. There is no reason that family members cannot be trained to help an ill loved one with a bath, provide a nutritious and therapeutic diet, give oral or even injectable medications prescribed by the doctor, and change a dressing on a wound. From the patient's point of view, the best part is that he will generally recover faster in his own home, close to loving family members and among familiar and comfortable surroundings. From the system's point of view, to provide care in the home is much less expensive than in the hospital. For a simple pneumonia, for instance, the Medicare DRG amount for reimbursement to our hospital is $2363.82. In our Agency, we can provide the patient with three weeks of Home Health care in the form of skilled nursing and home health aide visits for $1305.00. This is a savings of $1058.82! And, while the patient is recovering at home, the Home Health Care team will be coordinating community resources and teaching the patient and his family how to prevent the disease from recurring.

I have highlighted some of the good things about Home Health. Almost all of the negative things revolve around reimbursement issues. Upon admission, all of our Medicare cases are reviewed by a registered nurse at Blue Cross/Blue Shield, the fiscal intermediary for Medicare. Copies of the doctor's orders on every patient are mailed to Phoenix on admission and again in 60 days, if the patient is still on service. A determination is made in each case whether or not the services were medically necessary and at times, payment is denied for our services. In addition, this individual review takes a great deal of time and delays our reimbursement for weeks or even months depending on the workload at Blue Cross. This strict review and regulation of our services and the delays in reimbursement from Medicare are devastating to any agency, but especially to a small, rural Agency, and many times, we are unable to provide needed care to patients because they do not meet the strict Medi-

care criteria for our care to be reimbursed. In this area we do not have the resources to provide custodial or maintenance care for our senior population. While Cochise Aging Services provides many of these types of services, this organization does not have the funds or the staff to provide for all of the unmet medical needs of our seniors.

These reimbursement and regulatory problems have led to some innovative programs in our area. Our Hospital is offering a program to assist Medicare patients with medical expenses not covered by the Medicare program. These benefits include: a substantial discount on prescription medications and free delivery to the home, a discount on the Medicare inpatient deductible, free assistance in completing insurance forms, free hearing and hearing aid testing, free health assessments, and quarterly Affirmative Aging Seminars, which are also free of charge. The program is called T.L.C.—Total Life Care—for Seniors and is run through our Home Health Agency. Since we began the program in late August of 1985, we have enrolled nearly 800 senior citizens in the Douglas area. There is an annual membership fee of $10.00 per year which is affordable to those seniors on fixed incomes. The community's response to T.L.C. has been tremendous and emphasizes the concerns our seniors have about their health needs.

Another innovative approach to the reimbursement problems we have experienced involves a sharing of services. Our Home Health Agency at Southeast Arizona Medical Center in Douglas has contracted with Copper Queen Community Hospital in Bisbee to provide Home Health Care for patients in Bisbee. Together the two offices cover our corner of Southeastern Arizona and share resources and administrative expenses, as well as staff if necessary. While neither Agency could survive independently, the shared services and increased patient loads from two hospitals has allowed both agencies to remain viable and provide the Home Health services our patients need.

In conclusion, I believe that Home Health Care is the direction that medicine is now and will be taking in the future. With the high cost of providing care in the Hospital and with the reimbursement environment imposed by DRGs, it will become increasingly apparent that Home Health is an effective and relatively inexpensive way to provide care, especially for our Medicare population. In addition to being cost-effective, we hasten the patient's recovery in the most therapeutic of environments—his own home—while providing him with the knowledge and skill he needs to prevent or minimize further episodes of ill health. While each Home Health Agency has the responsibility to be innovative in controlling expenses and operating efficiently, we need help in solving our reimbursement problems, and most of all, assurance that federal Medicare regulations will not make it any more difficult for us to provide Home Health Services for Medicare patients.

If in the future, I can provide you with information or assistance, please feel free to contact me. I hope we can work together to ensure that the quality of and access to Home Health services for our senior community is not jeopardized.

Mr. KOLBE. Thank you.

Thank you very much, Mary, for that very interesting and informative testimony.

To conclude this panel remarks, and then we will go to questions, we have Stewart Grabel, who is the director of Cochise Aging Services, and known to probably everybody in this room or most of us, certainly.

Stewart has a law degree from Brooklyn College, but has been in Arizona for 13 years. He would certainly qualify to be a native by now and has been with Cochise Aging Services of the Catholic Social Services for 12 of those years.

He is the treasurer of the National Association of Nutrition, which is an aging services program.

Stewart, thank you for joining us today.

STATEMENT OF STEWART GRABEL

Mr. GRABEL. Thank you.

It is a pleasure to be here on behalf of myself and my staff. I would like to emphasize two things that make me different from

the other panelists here, and one is that we do not get any funding from Medicare. Our services are funded primarily from the Older Americans Act, from some state funds for home care, and from local contributions and donations which we are always willing to accept.

The problems that we face right now are unbelievable compared to when I testified a few months ago. One of the major issues that we are finding is keeping staff. That we have never had before, and that is in addition to competing sometimes for qualified staff to provide home care with the fellow panelists here. Cochise County has suddenly an influx of skilled nursing facilities, long-term care facilities, for which statistics indicate there is no need.

However, the salaries that they are paying has taken a number of people away from our staff. We have six openings right now, including an opening for a supervising nurse or registered nurse, and we have been having a lot of trouble filling it.

The other reason besides competing for salaries is the fact that our agency cannot fill the gap that Medicare leaves. There are too many people who need services that are not covered by Medicare, to the point where we are having to say no to almost more people than we can say yes to in terms of providing services.

We have been cooperating with, I think, most of the panelists here, except we have not gotten up to Phoenix yet. In terms of sharing our staff time with the Medicaid reimbursing time, we have been working somewhat with the county whenever we can. We share some staff in northern Cochise County, but the problem is that if staff working for Catholic Community Services are there to help people, because they are not in it for the money, and I do not think anybody in social services is in it for the money, then if they have to say no to people, they do not want to work there. If they cannot provide that help, there is an impetus for them to find other jobs—if they are going to be upset by the work that they are doing, they might as well make more money.

So, we have lost, as I said—we have six openings on the staff right now, four of them in our home care area. Also, since we depend heavily on Federal funding through the Older Americans Act, the Gramm-Rudman cuts have affected us very directly.

We are going to be cut by 10,000 meals for next year. That is 10,000 meals to homebound individuals less than we are providing at this point in time. We are trying to set up priorities for who to cut off, but the decisions that we are going to have to make are not going to be easy and they are not going to be pretty.

When we sat down with the area agency, Kathy Heard, and the State agency, and we went over the budget, the number of dollars that were available to us, we felt we had absolutely no choice at all. Our choice was to go even further in the hole than we are going into it this year, and to carry that on into next year or to say we cannot do it, we just cannot do it. We are going to have to find people who are going to be able to do without services.

Billie was talking about some clients up in the Bowie area. I got a message from Donna Fetterhoff, who is our case manager for northern Cochise County, and it includes the Bowie area, and one of the things is that there are so many people who are depending

on one another, the 70-year-old person caring for a 90-year-old person.

The 70-year-old person caring for a 55-year-old disturbed person or retarded person. We have those not only in Bowie but all over the community, all over the county. It really gets very difficult for us to decide who we say yes and no to. In my written testimony, I referred to a meeting that happened a week or so ago, where we were talking about what were we going to do when we got referred a patient, an elderly woman, who needs her medications done for her, set up for her daily because if we set them up for the week, she will over-medicate. She will overdose and she has been hospitalized three times for that.

So, our meeting was to decide how to get staff to be there every day to set up those medications. One of the options we had to decide on was whether or not we should cut another elderly gentleman off from getting his bath every week. Once a week, I am talking about, making it every two weeks. And if you do not think it makes it difficult to keep staff when we have to make those decisions, then you have not dealt with people. We are not talking about deciding whether to get a Chevrolet or a Cadillac or Toyota. We are talking about someone who is going to get their only bath either once a week or once every 2 weeks.

The situation has become much more critical since the last time we testified and case management has not done much to make it easier. Only case management helps us to have someone else to turn to, to help us decide who gets cut off. But the decision is still at the level where we are turning people off who need the services, who we could help keep healthy and help them in their homes, and we cannot do it.

We cannot, you know, we cannot get out to Bowie. We would love to be able to spend more time out there and we do work on everything we can. We came up with those frozen meals to send out because we could not afford to send someone out there every day. We could not pay the mileage.

My agency is running in the hole to the tune of $20,000 or $30,000 this year, and I have to explain it to the diocese in Tucson this Thursday. It is not going to be easy. It is not going to be easy, and the final answer is that there are going to be people who are going to wind up in these institutions because there are funds that have been floated to build these new institutions. We do not have to beat it. There is going to be pressure to compete with them for staff. There is going to be pressure to put these folks in institutions because the bookkeeping is easier.

If the doctor is right there and the billing facility is right there, and all those things are centralized, it is easy to keep track of. One of our problems with providing services out to Bowie is not only sending the worker out there, but sending the supervisor to supervise the work because all of our funding requires not only that the person has to be served, but that someone has to check to make sure the service is being done properly.

So, you have to multiply the cost of what is going on and I could go on a whole bunch longer. I just wanted to touch one more point, and that is USDA commodities or cash available for commodities for meals.

Congress was very, very understanding in terms of indicating that the funding levels for a return for cash in lieu of commodities for meals should be 56.76 cents per meal. However, the Department of Agriculture has, through some projects, determined that there is still not enough money for the 1985 reimbursements.

So, we are budgeted for next year at a much lower rate. I think it is 52.25 cents per meal. Even though Congress' intent was that we get the difference. Now, the difference is 6 cents a meal, 6 cents a meal translates to 6,000 meals in my budget.

So, it is very, very important that if we can bring pressure on the Department of Agriculture to fully allocate the funds very similar to what was being spoken about. The administration through rules and regulations is shifting what was apparently intended by Congress and making it more difficult for the service providers to get the money and to turn the money into services,

And, again, I would like to thank you on behalf of my staff because they have been even more frustrated than me. I have tried to smile and tell them do not worry about it, but they are very worried, and some of us have lost a lot of sleep over it.

Thank you.

[The prepared statement of Mr. Grabel follows:]

PREPARED STATEMENT OF STEWART GAMBEL, DIRECTOR, COCHISE AGING SERVICE
OF CATHOLIC COMMUNITY SERVICES OF SOUTHERN ARIZONA, INC.

CONGRESSMAN KOLBE AND CONGRESSMAN MCCAIN, I'D LIKE TO THANK YOU FOR THE OPPORTUNITY OF TESTIFYING BEFORE YOU. UNFORTUNATELY THE NEWS I BRING YOU IS NOT GOOD. THE STATE OF HOME CARE IN COCHISE COUNTY IS IN CRISIS. OUR AGENCY, WHICH PROVIDES SERVICE TO THE ELDERLY AND HANDICAPPED, WILL HAVE TO CUT 10,000 MEALS ON WHEELS FROM OUR CURRENT LEVEL OF PRODUCTION IN ORDER TO COMPLY WITH LOSS IN REVENUE DUE TO GRAMM-RUDMAN CUTS IN FUNDING. WE WILL LOSE AN ADDITIONAL 2000 HOURS OF HOME CARE SERVICES DUE TO THE SAME CAUSE. ALL OF THIS REDUCTION TAKING PLACE WHILE WE CURRENTLY HAVE WAITING LISTS FOR SERVICES.

I RECENTLY ATTENDED A STAFF MEETING, WHERE OUR RISING HOME CARE SUPERVISOR, THE NURSE DIRECTOR OF HOME CARE, AND THE CASE MANAGER REVIEWED OUR CASE LOAD IN ORDER TO DETERMINE WHETHER A 94 YEAR OLD PATIENT COULD GET BY WITH ONLY A BATH EVERY OTHER WEEK. WE HAD TO MAKE THE TIME AVAILIABLE TO PREPARE MEDICATIONS FOR AN ELDERLY WOMAN WHO REGULARLY OVERDOSES ON HER MEDICATIONS WITHOUT THE SUPERVISION. THE WOMAN IN QUESTION HAS BEEN HOSPITALIZED THREE TIMES FOR OVERMEDICATING. NEITHER IS COVERED FOR THIS CARE BY ANY EXISTING INSURANCE PROGRAM EITHER GOVERNMENTAL OR PRIVATE. BOTH ARE AT RISK OF COSTLY INSTITUTIONALIZATION, DEHUMANIZING LIVING CONDITIONS AND EVEN DEATH. YET BOTH COULD BE MAINTAINED COMFORTABLY IN THEIR HOMES WITH A REASONABLE LIFE STYLE WERE WE FUNDED ADEQUATELY TO PROVIDE THE LEVEL OF SERVICES THEY NEED. IT IS UNCONSCIONABLE FOR A HUMAN BEING NOT TO BE ABLE TO BE BATHED REGULARLY. IT IS UNCONSCIONABLE TO REQUIRE OUR STAFF TO MAKE THESE KINDS OF DECISIONS IN THE RICHEST COUNTY IN THE WORLD. IT IS UNCONSCIONABLE THAT MANY MORE LIKE THEM WILL BE INSTITUTIONALIZED OR HOSPITALIZED AT GREATER GOVERNMENTAL EXPENSE BECAUSE WE CANNOT EVEN GET TO THEM.

DONNA FETTERHOFF, OUR CASE MANAGER IN NORTHERN COCHISE COUNTY, REPORTS OVER 10 FAMILIES ON A WAITING LIST FOR SERVICE. THEY ARE OLDER AND MORE ACUTE IN NATURE THAN BEFORE. SOME ARE MULTI-GENERATIONAL WITH THE YOUNGEST IN THE HOUSEHOLD BEING IN THEIR 70'S CARING FOR PARENTS IN THEIR 90'S. IF ONE OF THESE CAREGIVERS GETS ILL OR NEEDS ADDITIONAL CARE, ALL ARE IN DANGER OF INSTITUTIONALIZATION.

WE HAVE INSTITUTED A CASE MANAGEMENT DEPARTEMENT WITH THE COOPERATION OF THE S.E.A.O.O. AREA AGENCY ON AGING IN ORDER TO HELP US EVALUATE THE CLIENTS NEEDS SO WE CAN PRIORITIZE WHO WE SERVE. BUT, SINCE SO FAR FUNDS FOR CASE MANAGEMENT CAME OUT OF HOME CARE SERVICE FUNDS WE HAVE LESS SERVICES TO PROVIDE THOSE WHO NEED IT. IN ADDITION THE LEVEL OF FUNDING FOR CASE MANAGEMENT IS NOT EVEN SUFFICIENT TO REVIEW EXISTING CLIENTS LET ALONE TAKE ON AND EVALUATE NEW ONES.

ONE OF THE RESULTS OF OUR INABILITY TO SERVE ADEQUATLY THOSE WHO ARE ELIGIBLE FOR SERVICE IS UNBELIEVABLY HIGH STAFF TURNOVER. OUR AGENCY AS I PREPARE THIS TESTIMONY HAS SEVEN OPENINGS, INCLUDING OUR DIRECTOR OF NURSING. WE HAVE BEEN ADVERTIZING BUT FIND IT TAKING LONGER AND LONGER TO FILL THESE POSITIONS. THERE ARE PROBABLY TWO MAJOR REASONS FOR USE NOT TO BE ABLE TO FIND QUALIFIED STAFF FOR THE FIRST TIME IN MY TWELVE YEARS IN THIS AGENCY. FIRST, MOST PEOPLE INVOLVED IN SOCIAL SERVICE INCLUDING OUR STAFF, WANT TO HELP PEOPLE. IN ORDER TO DO THAT, THEY NEED ENOUGH SALARY FOR THEIR FAMILIES TO MAINTAIN A REASONABLE STANDARD OF LIVING AND THE SATISFACTION OF HELPING THOSE LESS FORTUNATE THAN THEMSELVES. IF THEY MUST SAY NO TO PEOPLE WHO NEED THEIR HELP, THE SATISFACTION THAT COMES WITH SOCIAL SERVICES IS GONE. QUITE FRANKLY, WE DON'T PAY ENOUGH TO COUNTERACT THIS NEGATIVE DUTY.

SECONDLY, THERE ARE AT LEAST THREE NURSING HOMES OPENING IN COCHISE COUNTY IN THE NEAR FUTURE. THEY ARE PAYING HIGHER WAGES AND RECRUITING FROM THE SAME PERSONNEL POOL WE NEED. ALL PLANNING INDICATIONS ARE THAT THERE IS NO NEED FOR THAT MANY NURSING HOME BEDS, AND THE COUNTY HAS POINTED OUT THAT IT WILL INCREASE NURSING HOME COSTS TO THE COUNTY, AND YET OUR EFFORTS TO KEEP INDIVIDUALS IN THE COMMUNITY ARE BEING EFFECTED BY THIS TREND.

D.R.G.'S HAVE INCREASED OUR CASE LOAD GREATLY BY REDEFINING WHEN INDIVIDUALS CAN BE RELEASED FROM THE HOSPITAL, OFTEN WITH LITTLE OR NO REGARD TO THE DEGREE OF CARE AVAILABLE IN THE COMMUNITY. WE AND THE SOCIAL SERVICE STAFF OF THE HOSPITALS HAVE BEEN WORKING TOGETHER TO COOPERATE BUT WHEN WE GET A CALL FROM DISCHARGE PLANNERS ASKING FOR SERVICE--WHEN WE ALREADY HAVE ABOUT 70 PEOPLE COUNTY-WIDE ON A WAITING LIST--THERE IS LITTLE WE CAN DO TO HELP, EXCEPT ADD THEM TO OUR WAITING LIST.

IN SHORT, THERE ARE NOT SUFFICIENT FUNDS AVAILABLE AT THIS

TIME TO PROVIDE ADEQUATE HOME CARE SERVICES TO LOW INCOME HANDICAPPED OR ELDERLY INDIVIDUALS IN COCHISE COUNTY. EACH MONTH, FOR THE LAST FIVE MONTHS, WE ARE REFERRED ON AN AVERAGE, ONE CLIENT LIVING IN HIS/HER OWN FECES AND/OR URINE, WHO ARE UNABLE TO GET TO THE BATHROOM. TWO OR THREE THAT HAVE NOT BATHED IN WEEKS, AND MANY OTHERS NEEDING A LITTLE HELP TO ALLOW THEM TO REMAIN IN THEIR OWN HOMES. WE ARE LESS AND LESS ABLE TO MEET THESE NEEDS. OFTEN, IF WE COULD SEND DAILY, RATHER THAN WEEKLY HELP TO A CLIENT, THEY COULD STAY HOME. WITHOUT THE HELP, THEY MUST BE SENT TO A MORE COSTLY NURSING HOME.

ON BEHALF OF OUR DEDICATED STAFF AND VOLUNTEERS, I THANK YOU FOR ALLOWING ME TO LAY OUR--AND YOUR--DILEMMA BEFORE YOU. ON THE PREVIOUS OCCASION WHEN I TESTIFIED, CONGRESSMAN KOLBE ASKED ME HOW TO DEAL WITH THESE PROBLEMS IN THE FACE OF OUR BUDGET DEFICIT. I'D LIKE TO ONCE AGAIN STATE, THAT A CIVILIZATION THAT DOES NOT CARE FOR ITS ELDERLY AND DISABLED IS NOT CIVILIZED AND THAT FUNDS MUST BE FOUND TO CARE FOR THOSE WHO THROUGH NO FAULT OF THEIR OWN, NEED SOME HELP.

Mr. KOLBE. Thank you, Stewart.

I think that is excellent testimony to close this panel on. You certainly have given us an indication of the magnitude, all of you, of the problems that we are facing out here.

I am sure both John and I have questions that could go on endlessly, and I wish we had enough time for that.

John?

Mr. MCCAIN. Thank you, Jim.

I want to thank all of the panelists, particularly those who are in a repeat performance. I think it is very important that we put this situation in perspective over time, and it is pretty obvious that the generally accepted opinion is that things have not improved since the last year or so, to say the least.

I have a number of questions, and I will try to make them as brief as possible, but we certainly have a lot of ground to cover.

Robin, what rationale were you given for the change or the shifts in the rate structure that you describe in your written testimony?

Ms. KLAEHN. Mr. McCain, we have not been given any rationale for those changes. It is simply budget cutting, and that was one particular issue, I think, that really does need addressing, is the differential in providing services in a rural area than there is in a city where you can contain their visits, you can—the nurse can be appointed to a zone, and she can cover a few miles because there is an intensity of visits and there is a small geographical area, and it is extremely hard, and as Stu was saying, particularly what is truly amazing, was that the cost limit for a home health aide visit in the rural area is less than in the metropolitan area, and that is

the bath that Stu is talking about that is just so important to the patient.

And I cannot answer that because we have not been given any answer for that.

Mr. MCCAIN. Well, at least, maybe, we could, Jim, ask for some explanation. It may not be satisfactory, but I think you at least deserve that, given the circumstances in which you are trying to exist.

Ms. KLAEHN. That would be very much appreciated, Mr. McCain.

Mr. MCCAIN. Thank you, and we will try and get that answer to you.

Joan, I, of course, am very familiar with your work in the valley. We are very appreciative and, indeed, proud of the Hospice of the Valley and I think it has proven to be an eminently successful program, not just from a dollars and cents viewpoint, but certainly from one of human compassion and love and care and concern, which we sometimes have a tendency to forget when we focus on the dollars and cents aspects.

Mary Beth, I know how hard you have worked in these areas, and I would like to ask you and Joan both the same question because both of you had mentioned it.

You say that there is a definite requirement to reevaluate the regulations and change them. Could you be specific as to what those changes you feel are necessary in the regulations?

Ms. LOWELL. Because people are coming home with more intense needs, that needs to be reevaluated. People do want to stay home, and one of the issues that comes to my mind is intermittent care.

The way the rule reads now, they have to have certain frequency of visits, then their Medicare says well, they should not be home, they should be in the hospital. They are negating the patient's desire to be home. They are negating the family's willingness to take care of the patient and saying well, he needs that level of service even though it can be provided in the home, we are being told no, he has to go back into the hospital, and a lot of agencies are getting into trouble on that one because they are saying that the infrequency of care is too frequent.

Ms. ZANES. Well, the first thing that comes to my mind are the requirements for Medicare regarding payouts. One of the agencies I consult with managed to become accredited before the licensing people realized that their director did not have a BSN.

Now, in some small towns, you do not have anybody with a BSN or if you have a nurse who has a BSN, that nurse is your director of nurses for your hospital. So, you have to choose between whether you are going to have a director of nurses for your hospital or whether you are going to have a director of nurses for a home health agency.

Medicare does not allow for the combination of positions in small areas. In other words, if you have a staffing problem, you cannot take your director of your home health agency and give her any other responsibility.

So, I see that as something that should be addressed, especially in your outlying areas. I do not want to tread into the other professions, but I will say again, although I have a master's degree in social work and many years of experience, some of the best work-

ers I know do not have any extensive formal education, and I think hospitals and nursing homes both, in the delivery of health care services, have gone to a system in recent years where they have aides, physical therapy aides or assistants, who have been well trained by people with formal education that do a lot of the patient service, and give a lot of care to patients, and I think that could be done in home health or it could at least be looked at.

The other area I see is the double surveying that occurs with Medicare. Not just for home health, but across the board. Medicare surveys you, the State surveys you, joint commissions survey you. It just goes on and on, and this takes—this increases the amount of money you have to put out for staff time.

I think all the different agencies could get together and we could get by with one survey that everyone would accept.

Mr. McCAIN. Thank you.

Mary, I was very interested in your testimony, particularly when you expressed the opinion that, indeed, the DRG's have had, at least in some respect, a beneficial impact by driving down costs, and I certainly agree with that.

However, you did not talk very much about a problem that continues to surface in both Jim's and my office and that is the complaint of early discharge.

Could you share your views on that and what we might do to alleviate that problem?

Ms. CONLOGUE. Sure. I can only speak from the experience that I had in the hospitals where I have worked, and patients are discharged only on the order of the physician. The hospital is not the one that makes the decision that the patient is ready to go home. It is not the Medicare DRG system that decides the patient is ready to go home. It is the doctor that makes that decision.

Mr. McCAIN. Can I interrupt you a second?

Ms. CONLOGUE. Sure.

Mr. McCAIN. But if there were a physician here, many of them have told me, at least privately, that they feel immense pressures sometimes from the hospital to send some patients home earlier than they otherwise would.

Is that also true?

Ms. CONLOGUE. That is true, but there are just as many patients who stay way beyond the amount of time that we are going to be reimbursed for, that the hospital will be reimbursed for, and I think, you know, quicker and sicker is true, but I think that in a lot of cases, people blame the system, and it is not really the system, it is not really anybody's fault.

People are getting out of the hospitals, but they do have the availability of home health services, and I know that in some of the other testimonies, we heard this morning, it is not always stressed as an option when people are discharged.

In the area where I work, it is stressed as an option, and there are a lot of things that we can do at home in the continuation of services at home that would complement what was done in the hospital.

Mr. McCAIN. Well, Mary, do you also get the impression as we do that many of the people do not feel, I am talking about the pa-

tients, feel that they are properly represented at the peer review boards?

In other words, when there is a complaint that the patient was discharged too early, they are not properly represented, that this board is all too often the administration staff, and the doctors—there is not sufficient input by the actual consumer.

Ms. CONLOGUE. I have not heard that concern expressed in our area. I know that recently the hospital was required to distribute a letter to every Medicare patient that was admitted to the hospital, and the letter strictly outlined what they were to do if they felt that they had been discharged from the hospital prematurely.

So that this would give anybody on an individual basis the opportunity to appeal that to Medicare or to the peer review organization.

Mr. MCCAIN. Thank you, Mary.

Stewart, as always, your testimony is very compelling and dramatic and very much appreciated.

Who provides you with your funds?

Mr. GRABEL. Well, our primary funding source is Kathy Heard, the area agency on aging from SEAGO. It is through the Older Americans Act. We get additional funds through the State Supplemental Payment Program. We raise about a $100,000 from contributions or project income from people who receive the services, our meal services, for example. People donate an average of 70 or 80 cents per meal for a congregate meal when they get that meal, and then we do fund raising.

We have raised about $70,000 this year from fund drives, book sales, raffles, dances——

Mr. MCCAIN. Speaking engagements.

Mr. GRABEL [continuing]. Bequests. We have just scrambled. Unfortunately, we needed a $100,000 to make what we were budgeted for this year.

Mr. MCCAIN. Thank you. Now, according to your testimony, you are planning for next year, 1987, is that right?

Mr. GRABEL. Right.

Mr. MCCAIN. And you have been told that your budget would be cut to the point where you would have to cut 10,000 meals, is that correct?

Mr. GRABEL. Yes.

Mr. MCCAIN. And that is if Gramm-Rudman goes into effect, is that correct?

Mr. GRABEL. We——

Mr. MCCAIN. Is that accurate?

Mr. GRABEL. No; what has happened is that in our proposal for fiscal year 1986–87, which, in this State, begins July 1, in our proposal, we were given the dollar figures that were available from those funding sources.

Based on that funding level and the reduction in cash and commodities, that was the maximum number of meals that we could provide. Every year, we go back to basically a zero budget and build our budget based upon what funds are going to be available and what we can produce.

We are losing approximately $30,000, actually more than that, and it is not only directly from Gramm-Rudman. We have lost

$15,000 from Cochise County in revenue sharing funds that we were receiving. We have lost approximately $8,000 or $9,000 from the city of Douglas.

Many of the other cities have shifted funding over to the general revenue funds, so that, for example, the city of Benson and the city of Wilcox and Tombstone have all included us in their budgets by shifting it out of revenue sharing and we will be maintaining in those areas.

So, since not only Gramm-Rudman, but when it is added to the other budget cuts, it snowballs.

Mr. McCAIN. Can you give me an example, give this committee an example of the type of person and case that you had to say no to?

Mr. GRABEL. One. Becky Haskell is our head of nursing and she is back there. Becky, could you describe one of the ones you had to say no that you did not want to?

Ms. HASKELL. I had a desperate phone call a couple of weeks ago from a friend, a man who is a quadriplegic and lives in Bisbee. This man, while I'm not totally familiar with his financial status, does own a small business, and has a small income from that business.

This disqualified him for a number of programs which could help him. The man, as I said, is a quadriplegic, but he runs his business. I have been in his business, and he makes change by opening his drawer like this and reaching in and taking out a quarter.

Now, that is as much as he can move his body. This man needs help every morning to get up, get dressed, get to his business, and at night to get to bed. He cannot afford to pay for the help that is needed. He needs someone strong enough to lift him, and his request was for us to send two people in the morning and the night to help him do this.

This was absolutely impossible with our staff. We would have had to take services away from five other people in order to provide this.

Mr. McCAIN. Thank you very much for your testimony.

Stuart, in your usual candor, could you also be a little more specific about the institutions that are now being constructed?

Mr. GRABEL. I imagine that Carol Mordhorst from the Cochise County Health Department will speak of that more directly, but there is a new facility coming on the line in Sierra Vista. There is a new facility coming on line in Benson from which one of our home care operations, home health aides was hired to work at, and I am not sure, I have heard other plans for another one.

Mr. McCAIN. One was just built in Douglas.

Mr. GRABEL. Yeah. So, that is three, and in Cochise County and, again, the statistics, the population statistics and the health systems agencies all indicated that there was not the need, but each community wanted to have their own so they could keep their people local.

But, I am sure that Carol is going to touch on that.

Mr. McCAIN. Thank you.

Mr. GRABEL. I have heard her speak on it before.

Mr. McCAIN. Thank you.

Mr. KOLBE. In the interest of time, we are running a bit behind. It is not unanticipated, I guess. These kinds of hearings do.

Let me—I will just ask one question, and that is, we heard from three, at least, of the people that testified here about the delays in payments as being a major problem.

Is this a problem that is unique to Arizona? Are we talking both about Blue Cross-Blue Shield for home health care or are we also talking about Aetna as the reimbursing agent for Medicare? Is it unique to Arizona or is this something that is happening everywhere? Can you enlighten us?

Ms. LOWELL. Everywhere.

Mr. KOLBE. Not unique to Arizona?

Ms. LOWELL. No.

Mr. KOLBE. Joan?

Ms. LOWELL. No, it is not unique to Arizona. It is happening everywhere.

Mr. KOLBE. And even though there are different providers or different reimbursing agents in different States?

Ms. LOWELL. Right. One of the problems——

Mr. KOLBE. Is it the system?

Ms. LOWELL. It is the system. It is the crisis being put on them. One—we met with one of our intermediaries 2 weeks ago, and they said they had one secretary to process all the claims. They said do not send us any tracers, do not ask us for your money, because we are not able to do it.

It is partly the result of the forms that were put in, that they sit down and they read all those forms, and now what is happening is they are just rejecting claims if they are not to the letter, where, before, they might have, you know, been able to point and say hey, you left out people. Fortunately, that is not happening very often, but it is throughout the system, throughout the country.

I think Robin wanted to say something.

Ms. KLAEHN. Just another comment that it has an impact on the rural system, too. There is a periodic interim payment system for Medicare where an agency can receive a payment on a regular basis, that is every 2 weeks, based on their past record, but you have to be qualified for that in terms of size and length of service, and it is extremely difficult for small home health agencies in the rural area to become eligible for this.

Therefore, again, the rural agencies are being hit with additional problems that larger agencies in the cities are not.

Mr. KOLBE. Any other comments on that from the other panel members?

[No response.]

Mr. KOLBE. If not, again, in the interest of time, I think I will, although I have more questions, save them.

I want to thank the panel for very, very helpful testimony that you have given, and I know we will be wanting to follow up on it with you.

Thank you.

Ms. KLAEHN. Thank you very much.

Mr. GRABEL. Thank you.

Mr. KOLBE. We are going to take about a 3-minute break here to let everybody stretch their legs and then we will go to the last panel on public involvement. In fact, the last panel could come on up and take their seats, and we have an addition for those of you

who have an agenda, an addition to the last panel is Dr. Rhema Sayers. If you would come up also and take a seat.

[Recess.]

Mr. KOLBE. Could I ask everybody to please take their seats and the panelists to take their seats? We are going to go ahead and begin with the next panel. We will then have some time to take some comments from the audience.

We will begin with Kathleen Heard. Kathleen is, as we already know from the comments that Stewart made, will have some information for us on the whole issue as the head of the Southeastern Arizona Governments Organization, known as SEAGO. She has been working with SEAGO for the last 5 years, and then left for 5 years, and then has been back for 5 years.

She started work with the aged in this area in 1972. She has worked for community action agency for the State of Texas. She has a bachelor of arts degree in Latin American studies from the University of Arizona.

We are very pleased to have Kathleen Heard with us today.

Kathleen?

PANEL THREE: CONSISTING OF KATHLEEN HEARD, SOUTHEASTERN ARIZONA GOVERNMENTS ORGANIZATION, BISBEE, AZ; CAROL MORDHORST, DIRECTOR, COCHISE COUNTY HEALTH DEPARTMENT, BISBEE, AZ; JOSEPHINE MOSS, R.N., HOME HEALTH SUPERVISOR, SANTA CRUZ COUNTY COMMUNITY HOME HEALTH AGENCY; AND DR. RHEMA SAYERS, BOARD CERTIFIED FAMILY PHYSICIAN, DOUGLAS, AZ

STATEMENT OF KATHLEEN HEARD

Ms. HEARD. Thank you.

I would like to thank both Congressman Kolbe and Congresman McCain for convening this hearing today.

As I had hoped, the testimony that you have heard so far has classically illustrated the difficulties that we have in this country because we lack an integrated system for providing home and community-based services. And many of the witnesses have also given us some suggestions on how to correct some of these deficiencies. SEAGO, as the area agency on aging that covers Cochise, Graham, Greeley, and Santa Cruz Counties, contracts with four different agencies.

Presently, two of those agencies are public agencies, and two of them are private nonprofits. Those four agencies for the last 9 months have spent an average of 3,000 hours in individual homes. These are individuals that are either elderly or handicapped. They have served 645 of these individuals.

In addition, they have provided 80,180 meals to 735 individuals who are also functionally impaired in some way. But this only scratches the surface. We estimate that there are at least 2,700 individuals over 60 that are in need of some form of in-home service.

The requirements of State and Federal funding that provides the home care services, and by home care we mean housekeeping, home health, visiting nurse, and personal care services, are very cumbersome. They are very confusing to clients, let alone to service providers. SEAGO has requested permission from the State to ad-

minister three of these funding sources and consolidate the funding. We will be administering title III of the Older Americans Act, title XX, now called social service block brant, and a fund source through the State for SSI recipients, called State supplemental payments. We will be combining all of these fund sources and issuing one single contract to each of our service providers where, in the past, they have had to have three separate contracts. Clients will only have to complete one application form, where, in the past, they had to fill out three different application forms.

For example, a 65-year-old person, who is on SSI, would qualify for all three funding sources, would have to fill out the paperwork for each of the funding sources, and the reason that this has to be done is that no one single fund source can cover all of the costs that these people need.

The other thing that should be pointed out is that these fund sources only represent part of the budget. For the new year, beginning July 1, 1986, just looking at home care services, 32 percent of that budget in our four county area comes from non-Federal, non-State sources. This includes county revenues, which, in the past, have included revenue sharing.

But eliminating the duplication of these three fund sources is just one step to solving the problem that we have of a lack of a system of community-based care.

Last fall, we talked about the DRG's having had an impact on in-home services. Nobody can argue that it is inappropriate to keep somebody in a hospital who could recuperate at home with adequate support systems, but it must be recognized that these services must exist.

In our four county area, 22 percent of the people aged 60 and over live alone. They do not have anybody in that home to help them. In addition, those that are fortunate enough to have the support system cannot expect the support system to do everything every day.

Home health and visiting nurse services are needed to assure appropriate medical treatment, but other services, such as housekeeping, the installation of grab bars and a shower, respite workers to prevent caretaker burnout, are just as necessary. It also must be recognized that not only patients being discharged from a hospital are in need of in-home services.

Medicare and health insurance will not cover the cost of long-term home health and visiting nurse services, not to mention the cost of nonmedical services.

Senator Orrin Hatch has introduced a bill, Senate bill 1181, which addresses the needs to establish home and community-based services for functionally impaired individuals aged 65 and over.

This bill would authorize funds to provide in-home services to those elderly who risk being institutionalized or who are in a long-term care facility and could return to the community if home and community services are available at a lower cost to the Federal Government than that of institutional care.

These services could include activities to find eligible elderly persons, to plan and case manage services, to educate social service and medical professionals as to the availability of services, and to

coordinate and maximize the use of Federal funds and eliminate the duplication in the provision of services.

The bill calls for not building a service system, but using the existing service system, either as a Medicaid service system, in some States, or the area agency on aging network that exists in Arizona, for example.

Case management is vital in order to inform people about what are some of their options when they select services and case managers need to work very closely with discharge planners. We have heard a lot of negative feedback about the lack of discharge planning.

In their defense, many times, people in this area go to Tucson for specialized services. Those discharge planners could not possibly be experts on what is available in the home community. I think it is essential that we have case managers who are going to know those people over a longer period of time, longer than the discharge planner who just has a very short contact with the patient.

It is suggested that Arizona population aged 65 and older will double by the year 2000, and that 18 percent of this population will need some form of long-term assistance, ranging from minimal in-home support to intensive care in an institution.

If home and community-based services are not available, particularly in the rural areas like ours, more expensive, less appropriate services will have to be used. Thank you.

[The prepared statement of Ms. Heard follows:]

PREPARED STATEMENT OF KATHLEEN HEARD, SOUTHEASTERN ARIZONA GOVERNMENTS

ORGANIZATION, BISBEE, AZ

I would like to thank Congressman Kolbe and Congressman McCain for holding this hearing today. Hopefully, the testimony presented will help to illustrate some of the difficulties caused by the lack of an integrated system for providing home and community based services, and will lend support to efforts being made to correct the deficiencies that currently exist.

The SouthEastern Arizona Governments Organization, as an Area Agency on Aging, contracts with four agencies for the provision of home health and visiting nurse services in Cochise, Graham, Greenlee and Santa Cruz counties. These agencies also provide housekeeping and personal care services under contract. In the last nine months employees of these four agencies have spent an average of 3,000 hours per month in the homes of 645 functionally impaired elderly individuals and handicapped persons under age sixty. Some of these individuals also received a home delivered meal. SEAGO's contractors served 80,180 meals to 735 individuals during the same period. We project that an additional 2,700 older individuals are in need of in-home services that will enable them to maintain their independence.

The requirements for the State and Federal funding that is available for these services are duplicative and confusing to clients. Agencies providing home care services have separate contracts, one for Social Service Block Grants, a second for Title III Older Americans Act fund and a third for State funds to serve SSI recipients. Although the proposals and budget information submitted by service providers and the actual contract documents are almost identical, all other paperwork is different for each funding source. For example, a sixty-five year old on SSI would be eligible for all three fund sources and have to fill out three different application forms requesting similar information. Since no one fund source can provide the level of service that an individual may need, the pooling of fund sources is essential. In addition to these three fund sources, local funds, including county revenues, constitute thirty-two percent of the home care budget.

In an effort to eliminate this duplication SEAGO asked for and received State authorization to administer the Federal and State funding for home care and home delivered meals as of July 1, 1986. SEAGO will issue a single contract per agency purchasing services with the three funding sources. Service providers will have one system for reporting expenditures, service delivery and demographic data. Client will only complete one application forms.

However, the consideration of three funding sources is only one step toward establishing an integrated system for home and community based services, of which home health is an essential component. As was attested last fall, DRGs have increased the demand for in-home services. The inappropriateness of keeping a patient hospitalized who could recuperate at home cannot be disputed provided that a patient can get the help that is needed at home in order to get well. This help must include that of family and friends, if they are available, but it must be recognized that in this area over twenty-two percent of persons over sixty live alone. In addition for those fortunate enough to have a support system, this support system cannot do everything, every day. Home health and visiting nurse services are needed to assure appropriate medical treatment, but other services such as housekeeping the installation of grab bars in a shower or respite workers to prevent caregiver burn-out are just as necessary.

There must also be a recognition that not only patients discharged from a hospital need in-home services. Medicare and health insurance will not cover the cost of long-term home health and visiting nurse services, not to mention the cost of non-medical services.

Senate Bill 1181 introduced by Senator Hatch addresses the need to establish home and community based services for functionally impaired individuals aged sixty-five or older. This bill would authorize funds to providein-home services to those elderly who risk being institutionalized or who are in a long-term care facility and could return to the community, if home and community services are available at a lower cost to the Federal government than that of institutional care. These services may include activities to find eligible elderly persons, to plan and casemanage services, to educate social service and medical professionals as to the availability of these services, to coordinate and maximize the use of Federal funds and to eliminate duplication in the provision of services.

It is projected that Arizona's population over age sixty-five will double by the year 2000 and that eighteen percent of this population will need some form of long-term assistance, ranging from minimal in-home support to intensive care in an institution. If home and community based services are not available, particularly in rural areas, like ours more expensive, less appropriate services will have to be used.

Mr. KOLBE. Thank you very much, Kathleen.

Carol Mordhorst is director of Cochise County Health Department. She is a graduate of Wayne State University in Nebraska. She has a degree in business administration. She has worked in health care administration for 12 years and community health clinics and mental retardation, and she has been with the Cochise County Health Department for 3 years in an administrative capacity.

Two years ago, she was promoted as director, and I know we have worked with her very closely on a number of issues.

We are very pleased to have you with us, Carol.

STATEMENT OF CAROL MORDHORST

Ms. MORDHORST. Thank you.

As we have kind of alluded to today, as director of the county health department, I have a lot of responsibilities, and one of the major functions of the Cochise County Health Department is indigent health care. I realize that is not what we are here to talk about today, but I think it is important to see here in Arizona what the DRG system has also done to county government. To fully understand the responsibility of the indigent health care responsibilities, you need to understand that Arizona is the only State that does not have a Federal Medicaid Program. In 1982, our Arizona Legislature was authorized to implement a version of the Medicaid Program, called ACCESS. This stands for Arizona Health Care Cost Containment System. During this process, though, Arizona received a waiver for long-term care responsibilities that are generally provided under Medicaid. Therefore, the total responsibility for indigent health care in institutions in Arizona is the responsibility of the county.

Now, this is significant because when we are talking about people being let out of hospitals early and not having alternatives, one of the first considerations is to send them to a nursing home. Earlier, Stu Grabel talked about the nursing homes that are being built in Arizona. Right now, in Cochise County, there is either under construction or just opened 290 new beds, a 162-bed facility here in Sierra Vista, a 120-bed facility in Douglas, and a new 60-bed facility under construction in Benson.

Right now, my county budget anticipates about $3 million to take care of a 194 people in long-term care. What will happen when those 290 new beds are opened in this county? Obviously enough, the marketing people of those institutions are not going to allow them to be empty, and I am going to do everything possible in my department to prevent that.

Another one of the hats that I wear as director of the county health department is also the administrator of the county home health agency. We've had a home health agency since 1966. We have seen a lot of changes in the Medicare reimbursement since that time. Up until 1983, we were the only home health agency in Cochise County. Now, there are eight other home health agencies.

In 1982, the Arizona county spent $48 million on long-term care in Arizona. For this reason, the Arizona Legislature asked the Flynn Foundation to do a study of long-term care in Arizona. The

study concluded in 1984 with 20 major recommendations to formulate a comprehensive long-term care system in Arizona that would be funded by a variety of methods. This study recommended a network of formal and informal supports that were designed to allow persons to remain at home. As a result of this study, and due to the financial status of the county, which I might put in is partly due to the fact that we have lost our Federal revenue sharing, during the recent session of the Arizona Legislature, a bill was passed by the legislature to allocate $5.5 million to the Arizona county to develop alternatives for institutionalization.

One of the alternatives listed in that legislation is home care. Arizona counties have known for a long time that home health care can prevent premature institutionalization. The most frequent nursing services needed are like wound care, total care for bedbound patients, care involving catheterization, and we use a variety of staff to do this.

As I had indicated, we have seen a lot of changes in the counties since there has been the change in the Medicare system. There has been the change in home health agencies. As a result of this, I have also changed my agency.

You are aware and you have been told today that Medicare requires a recipient to be home bound, to have a need resulting from an acute illness, requires significant documentation and all of this causes much worry of the agencies who are for profit or who have low volume.

Just one or two denied visits can hurt their Medicaid waiver status. Therefore, the agencies cannot provide care as they might wish to due to the threat of being denied payments.

From January 1982 to January 1985, long-term care placements increased in Cochise County from 140 persons to 187 people. This was an average of 15 new people a year. During that same time, our long-term care costs to the county taxpayers rose from $1,896,000 to $2,884,000.

In 1984, I went to the Cochise County Board of Supervisors and asked for permission to provide skilled nursing, physical therapy, and home health services for those people that were potentially indigent. Those people that we saw coming to our office on a daily basis requiring nursing home care.

Their approval paved the way for the department to provide necessary care in the patient's home, whether Medicare paid or not. The county taxpayers will pay for this service, to remove the burdensome restrictions. By doing this, our department has been able to provide physical therapy, maintenance programs, that mean the difference of a person being in a $20 a day supervisory care home and a $48 a day skilled nursing home because they are ambulatory.

Furthermore, it has enabled the department to successfully develop other alternatives for a person who wants to return to their home rather than go to an institution.

In 1985, the Cochise County Board of Supervisors approved our Case Management Program and our Respite Care Program. Case management, as you have heard today, can provide for early detection of these illnesses. These programs were designed to coordinate and integrate efforts to achieve goals of prevention and timely health care service delivery.

Case management allows for early identification of individuals currently in need of services as well as those most likely to develop limitations due to disease or illness. In preventing disability or restoring people to independent living, we must know in advance what individuals will need in terms of care and then provide appropriate intervention, such as home health care or respite care.

Respite care provided by the county allows the informal care givers a break. This program provides for the necessary time away so that the care giver can willingly return to their responsibilities.

In addition, case management does provide that network for informing people that do not know what services there are available, and I know from firsthand experience those people generally do not care to know until they need the service, and then, unfortunately, there are not enough positions to go out and find where the services are, and that is where case management is very crucial.

These three programs were designed in my department to assure elderly individuals maximum independence and dignity in their homes. This year, I budgeted $2,806,000 for long-term care which was less than last year, because I felt confident that these programs are going to work.

Due to home health care and these other programs implemented thus far in 1985–86, there has only been seven new long-term care placements in Cochise County. In addition, those people that have been placed have been placed in lower levels of care, such as supervisory care, rather than the highest level of care, skilled nursing care.

To date, this fiscal year, due to these efforts, Cochise County has approximately $200,000 under budget for long-term care costs, but, more importantly than this, this program has allowed people to remain in their own homes. Elderly people do not want to go to a nursing home.

The nursing home is perceived by the elderly as a place to go when they are old and they are going to die. They are not ready for this. They will repeatedly tell you they want to go home. I think that programs, such as home care, can allow them to do that.

I also feel that it would be appropriate for the Federal Government to fully examine the Medicare and Medicaid requirements that dwell on acute illness rather than prevention. It is truly a sad state of affairs when you are not sick enough to qualify for Medicare coverage, and, yet, you are facing a future of institutionalized living if you do not get some assistance with the medical needs that you do have.

I appreciate the opportunity to provide my comments today, and I will certainly help you in any way I can.

[The prepared statement of Ms. Mordhorst follows:]

PREPARED STATEMENT OF CAROL MORGHORST, DIRECTOR, COCHISE COUNTY HEALTH DEPARTMENT, BISBEE, AZ

One of the major functions of the Cochise County Health Department is indigent health care. To fully understand this responsibility it is important to note that Arizona is the only state in the United States that does not have the Federal Medicaid program. In 1982, Arizona was authorized to implement an alternative to Medicaid called AHCCCS (Arizona Health Care Cost Containment System). During this process though, Arizona received a waiver on the Long Term Care portion of Medicaid, therefore, yet today, Arizona's counties are responsible for providing institutional care to the elderly and disabled of Arizona.

You are well aware of the facts that Arizona's population is growing and that the elderly population is growing.

In addition, the service reimbursement for the elderly has changed. What are the options for an elderly person being discharged from the hospital, not yet fully recovered? In the past and still now one of the first options is nursing home placement. This makes the county's burden of institutional nursing care even greater. In 1982-83 Arizona's counties paid 48 million dollars for long term care to approximately 4000 people. It is for this reason that the Arizona legislature requested the Flynn Foundation to conduct a study of Long Term Care in 1984. This study concluded with 28 major recommendations designed to formulate a comprehensive long term care system in Arizona that would be funded by a variety of methods. (See attached) This study recommended a network of formal and informal supports that were designed to allow persons to remain at home.

As a result of this study and due to the financial status of Arizona's counties, during the recent session of the Arizona legislature a bill was passed to provide 5.3 million dollars to Arizona Counties for the development of alternatives for institutional care. One of the alternatives listed in this legislation is Home Health Care. Arizona counties long ago discovered that Home Health Care can prevent premature institutionalization. The most frequent nursing services needed are skilled observation, diabetic care, care of totally bedbound patients, care of wounds, administration of medications and care involving catheterization. In addition to licensed nurses, other frequently used staff are home health aides, homemakers, physical therapists, occupational therapists and medical social workers. By utilizing these services in the home a person recently discharged from the hospital can return home rather than go to a nursing home.

Is the program cost effective? Cochise County has had a Medicare Certified Home Health Agency since 1966. We have seen tremendous changes in the Medicare picture before and after DRG's. Up until 1983, the Agency run by Cochise County Health Department was the only Agency in Cochise County. There are now 8 other home health

agencies in the county. Many of these agencies are associated with hospitals which provide the patient acute home health care upon discharge from the hospital.

As a result, the services provided by my Agency have changed. You are aware that Medicare requires a recipient to be homebound, have a need resulting from an acute illness and requires significant documentation in order for an agency to seek reimbursement. This causes much concern for agencies who are for profit or who have low volume. Just one or two denied visits can hurt their medicare waiver status. Therefore, agencies cannot provide care as they might wish to due to the threat of being denied payment.

From January 1982 to January 1985, Long Term Care placements increased from 140 persons to 187 persons, or an average increase of 15 new placements a year. During this same time Long Term Care costs to Cochise County tax payers rose from $1,896,000 to $2,884,300.

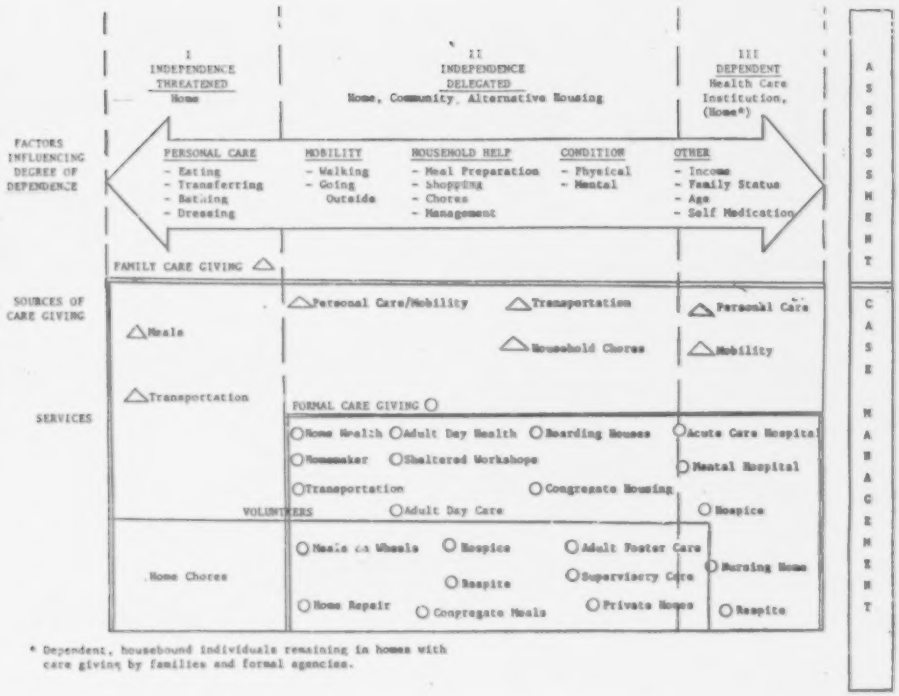
In 1984, I asked the Cochise County Board of Supervisors for permission to provide skilled nursing, Physical Therapy and Home Health Aide services to the potentially indigent. Their approval paved the way for this department to provide necessary care in a patient's home whether or not Medicare would pay. With the burdensome restrictions gone, the department was able to provide for physical therapy maintenance programs that mean the difference of a person being ambulatory in a $20.00 a day supervisory care home and being non-ambulatory in a $48.00 a day skilled nursing home.

Furthermore, this enabled this department to successfully develop other alternatives for persons who wanted to return to their home rather than go to an institution. In 1985, the county Board of Supervisors approved Case Mangement and Respite Care Program. These programs were designed to coordinate and integrate efforts to achieve the goals of prevention and timely health care service delivery. Case Management allowed for early identification of individuals currently in need of services, as well as those most likely to develop limitations due to their disease or illness. In preventing disability or restoring people to independent living we must know in advance which individuals will be in need of care and then provide the appropriate intervention such as home health care or respite care in order to prevent or limit the consequences of a disabling illness. Respite Care provided by the County allows an informal care giver time away from their daily care responsibilities. This program provides the necessary break to enable care givers to continue their services.

These 3 programs were designed to assure elderly individuals maximum independence and dignity in their homes. This year the County Long Term Care costs were projected at only $2,806,000 because of our intentions to implement these programs and our confidence they would be cost effective. Due to home health care and these other programs implemented thus far in 1985-86 there have been only 7 new Long Term Care placements in Cochise County. In addition, those persons placed have been able to remain in lower levels of institutional care rather than requiring skilled nursing level.

To date this fiscal year due to these efforts Cochise County is approximately $200,000 under budget in Long Term Care costs. But more importantly than this, the program has allowed persons to remain in their own homes. Elderly persons do not want to go to a nursing home. The nursing home is perceived by the elderly as a place to go when you are too old and going to die. They are not ready for that. They will repeatedly tell you they want to go home. I think that programs such as Home Care can allow them to do that. I also feel that it would be appropriate for the Federal Government to fully examine the Medicare and Medicaid requirements that dwell on acute illness rather than prevention. It's truly a sad state of affairs when you are not "sick enough" to qualify for Medicare coverage and yet you are facing a future of institutionalized living if you don't get some assistance with the medical needs you do have.

I appreciate this opportunity to share with you my comments on Home Care and will be available for any assistance I can provide to you in this matter.



* Dependent, housebound individuals remaining in homes with care giving by families and formal agencies.

Mr. KOLBE. Thank you very much, Carol. Appreciate those thoughtful remarks.

Our next individual to testify is Josephine Moss, a nurse with the Santa Cruz County Community Home Health Agency located in Nogales, where she has been for the last 6 years, and I understand you have a caseload of about 70 people there at your program.

Nogales is certainly an area with very unique problems, but similar to some other communities over here in Cochise County as well because of its location on the border, and Josephine has also worked on the Navahoe Reservation with the Navahoe Health Foundation.

We certainly appreciate your being here today.

STATEMENT OF JOSEPHINE MOSS

Ms. MOSS. Thank you.

It gives me great pleasure to speak for Santa Cruz County. In the 6 years that I have worked in Santa Cruz County, with the home health agency, I have found the needs growing each day.

With the dependency of our economy with the—with our neighbor across the line, we have found ourselves very depressed lately and a lot of the needs have arisen from the fact that a lot of the traditional home care givers, homemakers, have had to leave the home to find work, more or less, to keep the families going.

This has left a lot of the elderly, the handicapped, without their usual social and physical support that they were generally used to.

Another factor that is affecting these needs has been mentioned before; transportation. We are a very small community, but there is a very sparse population. If there is a lot of distances between people, families, and it takes a lot of our time to visit each and every one that does need our assistance. It is very time consuming and costly for us to cover these miles, to give one individual the care he needs.

The cost to the county for the long-term care in institutions for the medically indigent has become a very prohibitive issue, and lower alternatives, such as shelter or residential care, are not available to meet all these needs that are cropping up. In order to meet these needs that the individuals have in this community, we have been able to provide several services. One, which was mentioned, was case management. The other, skilled nursing, home health aides, and the homemaker service. It seems like a lot of service being given to such a small community, but when you take those services and divide it among six to seven individuals that make up our agency, it becomes quite a chore, and this means that we have to, more or less, limit and budget the care that we give each individual. But we have managed in our own way to save the county and the government several thousands of dollars by keeping these individuals at home. Many of the patients that have received these services have had conditions that have been quite severe, and this has been from the DRG's.

We have found that we have more wound cases to take care of that are not being taken care of. We have people with uncontrolled diabetes, that have to be taught.

We have people that are quadriplegic, victims of stroke, muscular dystrophy, and the very prevalent condition of crippling arthritis. It is a tragedy that the entire lifetime of contributions that these individuals have given has to go by the wayside, and more attention is being given to the young that can, in some way or other, provide for themselves.

The need for the additional services is greater in this area, and it is exceedingly difficult to help the number of patients needing the care. Much less give adequate services to those that we are assisting right now.

We have relied heavily on county, State, and Federal funds to provide the county with the home care needed. Even with these funds, many individuals are unable to get their benefits from the existing services because economically it has been mentioned they are falling between the cracks.

The term elderly means the 60 and over, but what happens to the ones that are 60 and under? They are the ones that are falling between the cracks. They are the ones that we are not able to serve, and in the long run, in future years, will become the people that will be institutionalized if they are not put on the healthful road.

The Santa Cruz County Agency has kept a lot of these people through the services that Medicare has not been able to reimburse us for. In fact, when we initially started the home care agency, we had had it Medicare certified, but we found that the difficulties in getting reimbursement were impossible. So, we put our certification on hold, and just went with the other funding sources that were available.

We did not have enough funds to provide for all the administrative costs that are needed in order to be reimbursed by Medicare.

As I mentioned, we do not have any other alternatives to send these people to. We have a home health nursing home care center there, which gives skilled nursing. They have just recently given some possibly intermediate care, but there are a lot of our people that could benefit from supervisory type of care.

Just some type of support care in the home, which we find is not adequate in that area. Another thing that we have found has affected us is the fact that a lot of the funding agencies, as Kathy has mentioned before, have been taking up a lot of administrative time in dealing with each and every form that comes in in order to make these people eligible for these services. Steps are being taken now to consolidate all these fundings, in order to give more direct care to the individual instead of eating up these moneys in administrative costs.

The increasing elderly population and the high cost of long-term institutional care to the taxpayers makes the provision of these home health care services more attractive as an alternative cost containment measure, as well as a more beneficial approach, considering the patients themselves.

This is what they would prefer, and this is what I have found more of the individuals wanting, is they want to stay at home. They want to have the support systems. They are able to manage. This, in the long run, I think, does save a lot of money to the Government in itself.

So, in the long run, I think that in meeting the patient desires and meeting their needs, can save us a lot of money with the home health supported systems that we are now providing.

Thank you.

[The prepared statement of Ms. Moss follows:]

PREPARED STATEMENT OF JOSEPHINE MOSS, R.N., HOME HEALTH SUPERVISOR, SANTA CRUZ COUNTY COMMUNITY HOME HEALTH AGENCY

The need for Home Health Care Services is continualy growing in Santa Cruz County. Not only for the elderly population which is increasing, as is shown in the national tables, but also excluded are the handicapped and thoes under sixty who do not fall within the current funding guidelines.

There are various factors that are having a big impact on these needs. The most important factor is the breakdown of the family support system. This is especialy true in our suffering economy. It is causing the traditional homemaker to seek work outside the home, while the family members who are elderly and/or handicapped are deprived of social and physical suports.

Another major factor is the difficulty in getting to medical facilities,either due to lack of transportation or difficulty in leaving the home because of chronic disabilities. Home Health has provided a liaison between these individuals and their physicians and has been instumental in helping them seek medical help when needed.

The cost to the county for long term care in institutions for the medicaly indigent has becom e prohibitive and lower level alternatives such as shelter or residential care programs do not exist. Consequently, Santa Cruz County has taken steps to meet the patient's needs in a more cost effective and more favorable treatment environment by supporting the Santa Cruz Community Home Health Agency. This agency provides a continuum of services coordinated to meet client and family needs in the home environment.

These services consist of:

1. Case Management: A service that assesses the person's needs and then coordinates all existing resources to meet those needs to the extent possible. In many cases the case manager follows a client's progress from initiation of care to either institutionalization or death. This service includes advocacy and assisting persons in benefiting from existing community resources.
2. Skilled Nursing: This involves the hands-on treatment of individuals that need skilled

nursing assistance in their homes to prevent a return to the hospital due to complications caused by improper care or neglect. It also involves the teaching of disease etiology and self care techniques to patients and their friends or families, in order to further promote a supportive home environment. NRG's are making this teaching more important due to earlier discharges. Skilled nursing also provides a liaison between the physician and his patient.

3. Home Health Aide: Many individuals are unable to perform all their activities of daily living with adequate safety. The home health aide services provides them with assistance in personal care, some skilled nursing under the supervision of a nurse, the monitoring of health status and simple but vital reassurance. In some cases, range of motion and gait training under the instruction of physician, registered physical therapist and/or home health nurse is also provided.

4. Homemaker Service: This service allows a large per cent of the clients to remain in their own homes. The homemaker provides the housework and meal preparation which the individual is unable to do safely for him/herself. It insures better nutrition and hydration for the individual. It provides a measure of safety and reassurance that comes from knowing assistance is near.

Many of the patients who have received some type of service have had conditions which have been quite severe. They include the terminal cancer patients, those with uncontrolled diabetes, quadraplegics, victims of stroke, muscular dystrophy and persons with crippling arthritis.

It is indeed a tragedy that following an entire lifetime of contribution and productivity, this youth oriented society chooses to allow its elderly to suffer from neglect and debilitating chr c disease with little or no assistance. The need for additional services in Santa Cruz County is great and in this economically depressed area it is exceedingly difficult to help the numbers of patients needing care, much less give adequate

service to those we can assist. We have relied heavily on county, state and federal funds to provide the County with the home care needed. But even with these funds many individuals are unable to benefit from the existing services because economically they have fallen between the cracks. They have incomes that are too high to meet the eligibility criteria, but not high enough to pay for these services without depriving themselves of food, medications and shelter. It is a hard choice for them to make but generally, medical care and home care are not obtained. This eventually leads to institutionalization that could have been prevented.

The Santa Cruz Home Health Agency has saved the County thousands of dollars that would have been spent on providing acute care or long term institutionalized care. This was done by providing the support services and skilled services in the home environment, which the clients greatly prefer. Although some are eventually institutionalized, it is not done prematurely due to a lack of alternatives. Santa Cruz Home Health is a licensed agency but has been advised by other home care providers to place Medicare certification on "hold" because of the difficulties encountered by others in the reimbursement procedures. These difficulties seem to stem from differing interpretations and progressively more restrictive rules and regulations and reporting requirements. Only larger agencies serving metropolitan areas are able to devote enough administrative staff time to securing reimbursement from Medicare. Additional administrative difficulties which make delivering a broad range of home care services exceedingly complex are the lack of a unified approach on the part of state and federal agencies to consolidate funding efforts into a single agency. It seems that several agencies in the state and federal governments are recognizing the advantage and need for providing Home Care services. However, small amounts of funding from several different agencies administered by several different sets of requirements make maintaining a focus on service delivery exceedingly difficult. Agencies in the business of supporting home care programs would be well advised to subcontract with one entity to administer the funds according to a common set of rules and regulations, eligibility guidelines, and reporting requirements. Administrative costs could be reduced which would result in more funding being available for direct care.

The increasing elderly population and the exceedingly high costs of long term institutionalized care to the tax payers make the provision of home health services an extremely attractive alternative as a cost containment measure, as well as a more beneficial approach form a patient care perspective. This has been proven time and again through the research over the last few years. It is time for elected officials to recognize this fact and act prudently to direct adequate resources to support this decidedly preferable alternative.

Mr. KOLBE. Josephine, thank you very much for that. Very helpful to us.

Our last person to testify on this panel is Dr. Rhema Sayers, who is a board-certified family physician in residency, graduate of the University of Connecticut School of Medicine and did a residency in family practice in a rural hospital in Pennsylvania.

She has been in private practice in Douglas since 1980, but also serves in a consulting position for Cochise County. It is, I believe, a city position for Douglas.

Dr. Sayers, thank you for joining us today.

STATEMENT OF DR. RHEMA SAYERS

Dr. SAYERS. Thank you.

As an add-on and the last person to testify, I am going to make this fairly short.

Basically, I am just going to give you an idea of what home health care does for the physician. Diagnosis-related groups have had a negative effect on small community hospitals, such as those in Cochise County. Trying to provide the care necessary for the recovery of the elderly or disabled patient can be a losing proposition within the restrictions of the DRG's, which pay for acute care only. Under the DRG's, the patient with pneumonia, for example, may be discharged in 3 to 5 days, often after incurring hospital charges exceeding the DRG-allowed reimbursement. Rural hospitals with between 10 and 50 beds have no opportunity for economies of scale. When a hospital has one hip surgery every 1 or 2 weeks, there is no floor devoted to orthopedics with no specially trained nurses and physical therapists, who can speed the patient's recovery and cut a day or two off of the hospital stay and save the hospital money. When a hospital only does 10 or 20 arterial blood gases a day, instead of 200 or 300, the needed blood gases cost more. Yet, the small, isolated hospital has to provide almost the same spectrum of care as the large city hospital.

For example, Douglas and Nogales, Holy Cross, are right on the border, and those two hospitals, in particular, have to provide not quite, but almost, the kind of care that you get in a tertiary care center, at least for stabilization and transport for the patients to get out of Mexico.

Home health care ameliorates the potentially negative effect of DRG's on patient care and on the hospital's finances. For the senior citizen with limited resources, which most senior citizens are, home health care is frequently the only alternative to the downward spiral of expensive supervisory care, financial exhaustion and welfare following a serious or debilitating illness and a hospital stay.

Many physicians do feel the pressure to discharge their patients as soon as possible. Frequently, sooner than we would have prior to DRG's. Prior to DRG's, particularly patients without family, were kept a day or two longer until they were able to care for themselves. Now, they can be discharged safely before they really reach that level with home health care providing continued professional care. A week or sometimes two of home health visits ensures the

patient's recovery and helps to alleviate the hospital financial burden.

One thing I think should be pointed out is that not all the home health care patients are elderly. Accidental injury can turn a healthy young man or woman into a paraplegic or destroy a leg or an arm or part of a brain within a few seconds.

After the initial extended hospital stay, often in Tucson, home health care can allow the patient to return to his community, his family, with physical therapists and nurses acting as the attending physician's eyes, ears and hands within the home.

From the viewpoint of the physicians in rural health care delivery, home health care is an absolute complement.

Thank you.

Mr. KOLBE. Thank you very much, Dr. Sayers.

I will begin with some questions. I will start down here with Kathleen, if I might.

Kathleen, I think, you put your finger on the real problem. We have all heard about duplications with State and particularly in this area of State/Federal funding, and the need to require different applications for all three of those in the very great added bureaucracy and paperwork in the system.

You said you are taking steps to eliminate that. My question is, Why have we not been able to do that before? Has it only been changes in the law that has permitted you to take steps to eliminate that or is that just something that just dawned on us, that we are really wasting a lot of time?

Ms. HEARD. I think some of it is that the State agency was not willing to put the programs together at the State level. Part of the reason for that is that the Older Americans Act restricts the State agency from providing direct services and for purchasing services directly without going through an area agency on aging.

So, therefore, under title III, the State agency had to recognize area agencies on aging. But, at our level, I think there has been—it has taken time for us to earn the respect of some of the other funding sources that are not familiar with title III, and I think we are finally coming to the point.

Maricopa started the experiment a year ago. They started in July of last year as being the funnel for these fund sources, and it was the first time that the State agency that administers title XX and administers the State program thought that there was the capacity at an area agency level to administer these funds.

We are the first rural experiment, and, hopefully, this will continue.

Mr. KOLBE. Kathleen, and also to Carol, since you have got the microphone, I am really interested in this problem or this—what is happening here in Cochise County with the sudden addition of a lot of skilled nursing home beds, and you attribute that to the lack of the certificate of need.

Is it your view that we need to—that that is something we should not have done away with? What is going to happen with these—I take it there really—you do not have the funds, and I take it there is not the private care or other insurance funds out there to do that.

What do you see happening 1 year or 2 years from now with the nursing facilities?

Ms. HEARD. Well, I think some of the problem is that we do not have the requirements anymore of certification of need for beds.

Mr. KOLBE. Should we?

Ms. HEARD. I think we should, yes.

The other thing is that many of these facilities are being built with bond money, and bonds are vital to our cities and towns in their economic development. But I think that there is a lot of education that needs to take place because when a city council is confronted with a developer who wants to build a 160-bed facility, it sounds very attractive in terms of the number of people that are going to get jobs, the number of families that may bring their people in.

However, these considerations are different at a city level than at a county level, and what is bound to happen is these places will either go bankrupt or they will find patients. They will find patients from other States, from other parts of Arizona. Those people will spend their resources and they will become eligible for county assistance under our current system.

Mr. KOLBE. Carol, would you like to comment on that? That is a very interesting scenario.

Ms. MORDHORST. Yeah. I think Kathy did a good job. She has been listening to me for too long, it is obvious.

I really agree, but I think there is one more factor that concerns me about the new facilities coming in. Certainly, they are, in many cases, funded with bonds, but you also need to understand what nursing facilities were available in Cochise County before these came in.

Five facilities provided skilled nursing care to my department prior to these new facilities opening up. There was a facility in Bisbee, Benson, Wilcox, Douglas, and Sierra Vista. Four of those facilities are linked with hospitals.

So, one side of the hospital provides acute nursing services, the other side of the hospital provides long-term care services.

I am very concerned that competition will have more of a drastic effect on what we may imagine because it may very well put—it may be the one thing that drives those rural hospitals out of business, too, because if they cannot compete on the long-term care side, which is a guaranteed monthly check from the county of $40,000 or $50,000, that makes their payroll, if they do not have those 20 or 30 people on those beds, because we now have placed them in a private institution that has got bonds, that can come in, that can cut their costs for 2 or 3 years, they are affiliated with large corporations that can take a loss in these early years, drive our hospitals out and then come back in and raise those rates right back up.

That is really what concerns me.

Mr. KOLBE. When you talk about that, the rural hospitals like in Wilcox, you talk about the swing beds, is that correct?

Ms. MORDHORST. No. Actually, our hospitals have been licensed as skilled nursing homes and, as a matter of fact, Northern Cochise received one of the highest ratings in the State of Arizona.

Mr. KOLBE. But, on swing beds, do we need greater flexibility then to go between skilled and——

Ms. MORDHORST. These hospitals, in some cases, like Benson and Wilcox, also have swing beds. So, they are actually long-term care certified. They are hospitals, and they also have the Federal swing bed program, and, you know, I think those things are good, but I am real concerned of what the competition will do, like with the 60-bed facility in Benson.

Mr. KOLBE. Congressman McCain has a question on that.

Mr. MCCAIN. Yes. What needs to be done?

Ms. MORDHORST. I am not so sure that we are maybe not already too late. I have probably got to be one of the primary ones. I have spoken out at every one of the meetings where they have proposed providing bonds to these new facilities.

I think there is a large need for education. I think the comment that Kathy made about cities thinking that this is going to provide jobs and industry. We do not see the whole global effect that it has like I do from my position in the county.

I think there is a matter of education. I think the certificate of need ought to be put back in place. I think there is a need to do something about the residency requirements because, currently, in the State of Arizona, you can walk into this county today and say I think I am going to stay here, walk into my office tomorrow and apply for long-term care, and it becomes the county's responsibility to put out that $18,000 or $20,000 a year for your long-term care when you have never spent any money on taxes in this county nor in this State, and I think it is—what we are seeing is a lot of people, especially in Sierra Vista, from military background.

We are seeing a lot of people coming from other States and other Medicaid facilities, coming to Arizona and becoming the responsibility of the Arizona taxpayers, and I think it is wrong.

Mr. KOLBE. My last question for Josephine and for Dr. Sayers.

You have both—both of you were—in fact, you were the only two panelists today that really touched on the particular problem of home health care and nursing care for young people, and something that has always struck me when I go to nursing homes, you see young people who have had catastrophic illnesses or accidents, very often accidents, of course, brain damage and so forth.

Are we doing enough? Are we really providing adequate care for those people who have, in many cases, very, very long-term needs for that kind of home health care or nursing home care?

Ms. MOSS. What I have seen out in the field, I have found that these are the people that are not getting the care that they really, really need. They do have family members that will take care of them, but like in your Alzheimer's, there is a large——

Mr. KOLBE. Young persons.

Ms. MOSS. No. Well, Alzheimer's is also a type of condition that causes burnout in family caregivers, and that is why I say with quadriplegics, with your young people that Dr. Sayers has mentioned have been in auto accidents that have left them completely handicapped, where they have to rely on other people.

I think this is where home health comes in. It not only gives the caregiver some respite from the 24-hour care that they have given, but also it gives them a support, a reassurance that there is some-

one there that they can depend on if they run into trouble, that can help them out, and I think this is what is sorely lacking.

Mr. KOLBE. Would you comment on that?

Dr. SAVAGE. Well, I really do not think that the facilities and the people, especially trained people, are available, at least in Cochise County.

For example, I do have one patient, a 27-year-old, who had severe brain damage, and she needs things like speech therapy, trying to get him speech therapy is a terrible problem in Cochise County. I just about cannot do it.

Getting him the proper amount of physical therapy. He is now on ACCESS. ACCESS does not pay for that kind of thing. He needs physical therapy every day, always. He has a job waiting for him, if he can get back to it. He has the potential to get almost back to it, and he has the potential for becoming a producing member of society again, if we can provide him with the kind of therapy that he needs.

Speech therapy, physical therapy, occupational therapy, psychiatric counseling at times, nursing care, and so forth. A lot of that is not available in Cochise County.

Mr. KOLBE. I will ask a question to Dr. Savage. Is the problem of citizens from across the border posing a real strain on our whole system of providing health care services here in Cochise County? I hear that it does in the acute care segment of hospitals, particularly in Douglas, for example. I have heard there is an awful lot of people for which there is no reimbursement, and that the county is really just absorbing that.

Would you comment on that, if that is true or not, and is that less of a problem as I guess it would be in the home health care and the other kinds of alternative care systems?

Dr. SAVAGE. Yeah. It is primarily a problem that we see within the hospital, and particularly the emergency room. We get vaccinations that are a couple of months early, have to be stabilized and transported, burn victims, accident victims, patients who have been so badly deteriorated in Mexican hospitals and then we are expected to somehow take care of them and save them.

What we usually do is we spend—it usually takes about 2 to 3 hours to stabilize a patient, get them the appropriate transport arranged, and operational and get the patient going, and it takes a lot of supplies, nursing hours, physician hours, so forth.

So, it is a big expenditure for the hospital. It does not involve home health care particularly because those people, when they come back, usually end up across the border and we do not extend over there.

Mr. KOLBE. Thank you.

I want to thank this final panel for their outstanding presentations and contributions to this whole area. A lot of very, very interesting testimony, and I think all of us are going to think about.

We want to thank you very much for your testimony.

We are going to go to public comments from the public now, and what we will do is if you will just leave a chair there, and if you will just come up and sit down at one of the chairs. We do have the microphone, and we want to be sure to record you.

We are running behind, and we would like to keep the comments just as brief as possible. The agenda says 2 minutes apiece. If we could do that, we will appreciate it very much.

Would you begin by identifying yourself? Yes, ma'am? Go ahead, please.

STATEMENT OF MARY ROBINSON, DOUGLAS, AZ

Ms. ROBINSON. Yes. I am Mary Robinson.

I will not use the phone because, although I have lived in Douglas for 77 years, the smoke has not affected my lungs.

Mr. KOLBE. Mary, we are pleased to see you again today. I saw you just last Saturday.

Ms. ROBINSON. I am on the board of Southeast Arizona Medical Center and, first, I want to compliment you both for helping Douglas in the peso devaluation of $123,000 and the Job Training Program for Cochise College, which we brought in. It was $90,000, and I am also on the board of the Douglas Area Food Bank.

I have one thing that I would like to mention, which has not been mentioned here, and that is, that the Medicare prospective pricing system has contributed to the financial problems of rural hospitals and Medicare pays rural hospitals substantially less than urban hospitals for many of the same procedures.

You may not be aware of this, but there is what is called a hospital capital expense that is paid by the Federal Government to hospitals. Now, for urban hospitals, you would only have to have 15 percent of a disproportionate number of the poor in order to get that money. For a rural hospital, you have to have 45 percent of disproportionate care for poor in order to get that money.

For instance, in our hospital, which is Southeast Arizona Medical Center, we have 79 beds. The Medicare SSI patient, for instance, to total number of patients may be in a month 10.4, ACCESS 22.0, so we would have 32.4.

As you can see, we would get less money than an urban hospital.

Second, we are not only a rural hospital, but we are a rural border hospital, which means that we have greater burdens. You were speaking about the aliens. Now, in the month ending in March 31, 1996, the 12-month period, for in-patient aliens, we had to write off 13.2 percent, and for out-patient emergency aliens, we had to write off 78.1 percent.

In order to have home health care agency, we have to have money, and we do not like to be discriminated against.

Third, we need in rural hospitals to be considered with reference what might be called unique outlyer patients, which is unique catastrophic patient, because in a small rural hospital, and ours is a not for profit hospital, we were fortunate to have CHOMA, the community hospitals of mid-America, buy the county hospital, and they have put in the last 4 years $1 million to build up that hospital, and as you can see by the representatives we have here, which is Dr. Sievers, the chief of staff and on the board of the hospital, and Ms. Zarate and Mary Conlogue, you can see we have not only a lot of care, but we have a lot of caring and that is very important.

Now, I should also like to speak. I am 77 years old, but I am not speaking as an old woman because there is a Spanish proverb that

says, "If you don't move, you're going to be like an old wine barrel. The only thing left will be the hoops and the smell."

Therefore, I move. Now, the other part I would like —that is probably more than my two minutes, but I would like to address the Notch group.

I have been working——

Mr. KOLBE. You are correct.

Ms. ROBINSON. I am sorry.

Mr. KOLBE. That is all right.

Ms. ROBINSON. I have been working with the 800 people on total life care with Mary Conlogue, going from house to house, and if you see me a little bit slimmer than most senior citizens, it is because I walk miles and miles to these homes, and I have found a lot of ignorance about Medicare and what it pays.

The Federal Government is not educating the people to what Medicare really pays, which is not, which is not 80 percent of the cost. I believe the Federal Government would not have to have too much money to get education out to those people, and the second and the last thing which I feel is very important for the Federal Government to give is Federal attention to prevention.

That is it. I have a lot more, but——

Mr. KOLBE. Mary, thank you for those comments. Terrific comments. I knew when I listened to you last Saturday in our town hall, that I was listening to——

Ms. ROBINSON. I did not prepare anything.

Mr. KOLBE. Because she is standing, I would like tc take the lady with the chair.

STATEMENT OF BESSIE HOLMES

Ms. HOLMES. Yes, sir. I am Bessie Holmes. I am a receiver of medical care. I am also an R.N. of 50 years.

I think that Medicare needs overhauling. Their administration stinks. I get, in the computer, I get duplicate bills and I think this is where a problem is. I think you people—I was just getting ready to write you both and I found that you were——

Mr. KOLBE. Saved you the 22 cent stamp.

Ms. HOLMES. Yeah, and a lot of effort when you have arthritis.

I want to know what this Gramm-Rudman—I object to having 1 percent of my benefits turned over to balance the Government budget, and I know you both voted against it because I investigated.

But, I get so many duplicate reports. If I was not a nurse, I could not understand them. I help many of my friends with their Medicare because they cannot read them, and they waste so much paper, sending us crazy things.

So, I think—I have lost track of who is in charge, but do you think that we—how is the feeling in Congress on this thing?

Mr. KOLBE. Let me just address that, Bessie. John can comment as well. Gee, I hope I do not lose your vote, but I do want you to know I did vote for Gramm-Rudman.

Ms. HOLMES. Oh, you did?

Mr. KOLBE. Yes, ma'am.

Ms. HOLMES. I was told you voted against it.

Mr. KOLBE. It does have a limitation, as you suggested, of 1 percent reduction in the health care component, while other things, such as defense and other programs, education programs, can absorb much larger cuts. This last year, it was 4.7 percent cut in other programs. Medicare component is limited to 1 percent.

It seems to me that there are two comments I would make.

One is that if Congress does its job and establishes its priorities, the automatic cuts, including the 1-percent cut in health care, Medicare, would not have to go into effect.

Second, if there is going to be a 1-percent cut in that, there are ways in terms of the administration, which you alluded to, the poor administration, that we ought to be able to take those cuts out of administrative costs overhead without having to cut the direct services to individuals who are Medicare recipients.

John?

Mr. MCCAIN. You were misinformed about me, too, Bessie. Let me just point out to you, this year, we will have a trillion dollar budget, $1 trillion. This is the first time in our history. Fifteen cents out of every dollar in that budget will not provide Medicare benefits, will not buy any school lunches, will not buy any bullets.

Fifteen cents out of every dollar in that trillion dollar budget only goes to pay off the interest on the $2 trillion debt we have already accumulated.

We cannot mortgage our children's futures by continuing the terrible and unconscionable behavior patterns of the Congress of the United States along with the President that allowed us to accumulate a $2 trillion deficit.

If we continue as we are doing, by the year 1995, 42 cents out of every dollar in the budget will go to pay the interest on the national debt.

Now, I believe that the Congress can balance the budget. They can meet the Gramm-Rudman numbers without cutting Medicare 1 percent or half a percent or a quarter percent. We also need to find better ways to administer, better ways to clean up the confusing paperwork you receive.

The DRG's have succeeded in bringing the escalating costs of health care under control. I know of no rational people who want to do away completely with the DRG's. We want to do away with abuses. We want to do away with the sicker and sooner aspects and all the other problems.

But I do not think we could have continued to afford the dramatically escalating costs of health care, which were basically driving Americans out of the market for health care, whether they were on Medicare or not.

So, please, be aware, that the Congress of the United States has a responsibility not to cut your Medicare, but we do also have the responsibility not to mortgage our children's futures and we must bring this deficit under control. I believe we can do both if we show the political courage to do so.

Ms. HOLMES. Then, I can remember what my father-in-law said. He said that I guess mother and I are going to have to die sooner than we want to because we are using up our savings, and this was several years ago, and——

Mr. MCCAIN. Before Gramm-Rudman?

Ms. HOLMES [continuing]. And we have already used our savings. We have nothing but Social Security. We are 80 and 81, and we pay our insurance before we buy food, but something has to be done about Medicare.

There is too much politics in it.

Mr. KOLBE. Well, Bessie, I want to thank you for your comments. I think that I speak for both John and for me when I say that we certainly want——

Ms. HOLMES. I know a little bit. I know how mixed up computers can get.

Mr. KOLBE. Well, that is certainly true, and I must tell you that my office and my case work staff deals with those problems a great deal, and it can be extremely frustrating for people, certainly people of your age and very disconcerting to have these kinds of duplicative bills.

Ms. HOLMES. That is right. I try to think young, and I still have my faculties.

Mr. KOLBE. We can tell that you do.

Thank you very much, Bessie, for your comments.

Ms. HOLMES. I am going to sit down.

Mr. KOLBE. Yes, please. Thank you.

Yes, ma'am? On the end there.

STATEMENT OF BOBBI STRAUB, TUCSON, AZ

Ms. STRAUB. My name is Bobbi Straub. I am the manager of Travenol Home Therapy in Tucson, AZ.

This is the first time that I have been literally exposed to this committee, and I want to say that I am impressed with the dedication of the people.

Bessie, you have got enough people that care about what is happening that together I think we can make it go.

I want to say to our congressmen that I realize adamantly how much we need to have you go back to Washington to tell our story. We are the people on the frontline that are taking care of these ill people at home.

I represent the equipment. We are the DME vendor. So, I would like to share just a little bit about what is happening because I have heard so much from the home care skilled nursing faculty and what would you do without the equipment.

It has been probably a year ago when Robin Klaehn called me from Tucson because a very dear friend of hers was dying of cancer, and she said, "Bobbi, I'm not sure what kind of reimbursement we're talking about." I said, "It doesn't matter. What does she need?" And, Robin made the comment to me, this had been the first time she had the opportunity to be a first line provider again, and she chose to take care of her friend and said, "Without all of the equipment that you delivered, I couldn't have done that."

We are the ones, when the DRG's are forcing out patients and that discharge planner is calling and they are coming out of the ICU saying they need suction, they need monitors, they need oxygen, we scramble to get the equipment out there, and in 1984, which has been the most recent study of the American Respiratory Therapy Association, it costs the hospitals $275,000 a year to keep

a patient on a ventilator in the ICU. We can take care of that patient at home with the skilled nurse in the home for $25,000.

Now, as of 2 months ago, Medicare just inadvertently cut our reimbursement as a home care provider and instead of paying me 80 percent of $550, they now pay me 80 percent of $390. I have no say in this. They do not tell me they are going to do this. It simply appears on our Medicare reimbursement check, and I think we all need to realize that in Arizona, particularly, in my line of this industry, we have the very lowest profiles of any State.

We cannot afford to have us be quarreling amongst ourselves about how are we going to take care of the ill. It does not matter whether it is the elderly. Bessie is asking us to take care of her. What about the young quadriplegic that was in a wrestling accident that we are taking home on a ventilator tomorrow? My company, Baxter-Travenol in Chicago, is saying, Bobbi, have you done a cost analysis.

With what Medicare or the insurance providers are going to give you, are you going to be able to make that a possible venture, and because that is my call, it does not matter. It is like Robin calling me, but I need to be a prudent businessperson, too. So, we all need to be working together and have you go back to the Federal Government and say who is doing the planning. When we have got people in rural areas, and I deal with the rural areas a great deal, from Tucson, all of a sudden, Medicare says to Bessie, she will get a letter in the mail, we are no longer going to pay rental on this piece of equipment. Now, it is going to be purchased. We are going to give you 2 more months and then you need to work it out with your vendor to purchase that piece of equipment.

Now, I have got a hospital bed, a concentrator in a rural area. I have got a call from a confused person saying what does this mean. I am not sure what they want me to do, and Medicare is saying to me, you have got a choice, you can send out a truck and a person, give that person a new piece of equipment and we will pay you 80 percent of the allowable we gave you, or you can sell that as used equipment. No out of pocket money from the patient, but you will accept 75 percent of your 80 percent allowable as payment in full and you will give us a warranty just like you would on a new piece of equipment.

We have formed many, many groups, like NEAMS, to lobby in Washington because we cannot do that. You have also got a situation where the hospitals are looking for revenue, so they are competing with the normal DME vendor. They are trying to lease, purchase, put out equipment, joint venturing.

Competition is healthy. Not when we are competing in the care of that patient, and I think all of us need to be certain that we are focusing our attention on that patient. If we are all working toward that goal, quit confusing Bessie with volumes of paperwork. I have seen it, Bessie. It is astronomical.

We have patients come in with papers like this, and we try to work through it. I am paying a full-time person to help that Medicare beneficiary understand what they are trying to say.

So, we are all here for the same reason, we are ready to give quality care. It is easy to talk about that, it is easy to say we are all here to see quality of life increase. That does not happen if we

do not have the support of our Congressmen who are going back and say this is the testimony from the people who are on the front-lines, who are honestly taking care of those sick people at home. Let us make it work.

Mr. KOLBE. Thank you very much for those comments. Very helpful.

Yes, ma'am?

STATEMENT OF ENID SCHWARTZ, SIERRA VISTA, AZ

Ms. SCHWARTZ. My name is Enid Schwartz. I am a registered nurse. I have my master's in science with a specialty in gerontological nursing, and I am a certified gerontological nurse specialist.

I live here in Sierra Vista and I teach for Cochise College. Carol Mordhorst made a comment before about preventitive care, and I have two comments to make.

One is in relation to preventitive care. That is my soap box. I feel that we tend to be an illness-oriented society, not a wellness-oriented society. If we paid more attention to preventitive care, then I believe very strongly that there would not be a strong need for nursing home care, for home care per se, because people would be healthier, and I believe that is from youngsters all the way up to old people.

If older people knew how to take care of themselves better, then they would have less problems and would be able to be at home, would be able to be self-sufficient without any needs.

I also wanted to make a comment on what Mr. Cooke said in relation to the increased education in gerontology. I feel very strongly that this is real important. Not only is it important for those of us who take care of the older adults, to have more information in what happens as we age, but also for the older adults in relation to what is important for them to know in their own—what is the difference between illness and wellness? Where in your aging process are you to the point where you are no longer a normal aging process, where you an abnormal aging process and where it is time to really get some good care?

I have offered my services in the community in relation to education. One of the big problems is finances. People do not have the money to pay me. It is fine to do an in-service every once in awhile in the rural area, in my area where I do not have to pay for my transportation, where it is not that far. It does not take that much hours out of my day, but to go to Wilcox, they do not even have money to pay for me to travel to Wilcox, let alone to give me $10 an hour to speak. There is no money for that kind of thing.

As much as I like to give my services, I also spent a lot of money to get where I am, and feel that some reimbursement would be nice. So, that is a real big problem.

Mr. KOLBE. Thank you very much for those comments. All of you, we appreciate it very much.

Are there other comments from members of the public? If you will come forward here, we will exchange places here.

Thank you all very much.

This will be our last one, because we are running behind.

STATEMENT OF SANDRA THOMAS

Ms. THOMAS. Yes. My name is Sandra Thomas.

And I would like to express my appreciation at this time for the care Cochise Home Health Agency has provided to my son, who was left a quadriplegic following a shooting accident in April 1985.

My parents are retired senior citizens and are limited in the help they can give us. Cochise Home Health Agency provides physical therapy for Edward twice a week as well as taking his vitals, check for pressure spots or other problems. In addition, they check his catheter and urine train bag. All that is recorded and reports sent to the doctor, who evaluates the information and gives orders for further medical treatment.

The program aids us in getting Edward up and situated in his chair for the day. This is very important. Also, as he is a very large young man, 6 foot 2 and about 230 pounds. A respite person comes in twice a week from 12 noon until 4 p.m., when I return from work, which relieves my parents and frees them to shop, make medical appointments, or give them time for relaxation.

Helping Edward further in education and preparing for the GED testing has been a major goal. However, having a young man, male companion, has been helpful to him also. This man was paralyzed from an injury in Vietnam and has progressed to where his handicap is undetectable, which gives my son positive reinforcement for continuing therapy.

Counseling is provided on a weekly basis in order to help my son work on his emotional situation, which must be an emotional situation that must arise. We talk with Edward a lot, but we lack the skills to know what needs to be done for his inner frustrations.

Cochise Aging Service comes in two mornings a week to bathe him and give oral care. These qualified people provide us with services that could only be gotten in a handicapped institution. I certainly could never have afforded to pay for them, not to mention the fact that I could not hold up physically to work 40 hours a week and continue to give Edward the care he needs.

The Cochise Home Health Agency is a worthwhile service and without it, others like Edward would be neglected. The progress Edward has continued to make in the last 7 months is attributed to the care given through this Government-funded program.

Seven months ago, Edward could only move his head and had very limited movement in his right thumb. He can now feed himself soft foods, operate his motorized wheelchair and is regaining some movement in his left arm.

Thank you.

Mr. KOLBE. Ms. Thomas, thank you very much for those comments.

I think your comments put a very human face on all this that we have heard today. I know it is very easy for us to listen to the testimony and talk about DRG problems and throw facts and figures and statistics around.

The comments that you, Ms. Thomas, have made about your son and the kinds of services that are being provided by Cochise Aging Services tells us the need for this kind of service. And I know that what you had to say will leave a lasting impression on me as I go

back to Washington as a policymaker and have the responsibility for trying to decide how we are going to provide these services and as John has said at the same time, make sure that we do not bankrupt our children with this continuing Federal deficit.

I do appreciate very much what you had to say.

John, would you like to make a closing comment?

Mr. McCAIN. Well, I would like to thank Mayor Jean Randle and all of the staff here who have done so much and also your staff, Jim, who have done so much to make this hearing possible.

I think it has been one that covered some very important issues and one that will be of great value to me, and I know to you, as we try to address these issues and problems that continue to face us in health care.

I want to thank you again for making this possible.

Mr. KOLBE. I want to thank all of the audience for this, and do want to pay special tribute to the staff, who have made this all possible,

From John's staff, Jan Lemon, who worked very hard on this. Billie Fabian, who is my assistant, runs the Sierra Vista office. I think many of you know her in Tucson. Pat Klein, who worked very hard on this.

One last person, who was helpful in getting some of the material ready in Washington and has been my intern back there this last semester, now home in Sierra Vista, Bitsy Irons. Bitsy, welcome back to Sierra Vista. We are glad to have you back here.

Our thanks to Sierra Vista, the city of Sierra Vista, and their people. To Jean Randle and the staff here for making this possible, but most of all, our thanks to all of you who have given us very able testimony today, and I think made this a very useful hearing, for both John and me. And I think for the entire aging population in southeastern Arizona.

Our thanks to all of you for participating in our hearing.

Thank you very much.

The meeting is adjourned.

[Whereupon, at 12:50 p.m., the hearing was adjourned.]

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